

**Communication between Nurses and Patients
in HIV/AIDS Counselling, in Thailand**

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Abstract

This study into HIV/AIDS counselling was conducted in hospitals in a northern, rural agricultural province of Thailand. It differs from previous counselling research in Thailand that was undertaken using ethnographic methods to indicate what the nurse intends to achieve and how she expects to conduct counselling. Previous research has shown nurses' thoughts about what they felt they should do in counselling, and how patients felt about counselling services. In contrast, this study illustrates '*what really happens*' and what the nurse and patient have done in counselling. This study is the result of six months' field work, during which 43 counselling sessions were recorded on video: some sessions were held in the hospitals and some in patients' homes. The recordings, obtained with informed consent, were the primary data for this study. The recordings were analysed using a hybrid methodology: a form of '*ethnographic conversation analysis*', which is a sequential approach to identifying how certain topics (such as sexual conduct, the prospect of death etc.) are initiated and pursued. The main focus is not the technical detail of conversations, but what topics are discussed and how those topics are managed within counselling. In the contextualized micro analysis, the structure of Thai counselling interaction was found to be cyclical, differing from the linear or step-by-step pattern found in general health consultations in western countries. Throughout the discussions many themes were covered. Four themes were highlighted: joining and selecting for the programme of antiretrovirals, disclosure and confidentiality, sexuality and the prospect of death. The nurses always initiated the topics and the patients were more passive.

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Dedication

I would like to express my sincerest thanks to all Thai HIV/AIDS sufferers. Before this study was finished, several people who devoted their lives to get involved with this study passed away. Whatever is regarded as merit and contribution emerging from making use of this study is devoted to those dead people.

I deeply sympathise with you and your families.

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กว่าปริญญานิพนธ์ฉบับนี้จะเขียนเสร็จ ผู้ป่วยหลายคนได้เสียชีวิตลงก่อนวัยอันสมควร
ประโยชน์อันใดที่เกิดจากการใช้ปริญญานิพนธ์ฉบับนี้ ผู้เขียนถือเป็นกุศลและอุทิศให้กับผู้ป่วย
ที่เสียชีวิต ผู้เขียนขอแสดงความเสียใจต่อทุกคนรอบรั้วที่สูญเสียบุคคลอันเป็นที่รักจากโรคนี้

Author's declaration

This thesis represents original work in which the analysis of its materials was performed solely by the author. Some sections of the thesis have been delivered at conferences.

In particular parts of chapter six have been presented for the poster no. MoPeE4106 at the XV International AIDS Conference,—การประชุมนานาชาติเรื่องโรคเอดส์ ครั้งที่ ๑๕ ณ กรุงเทพมหานคร, 10 – 16 July, 2004, Bangkok, Thailand. Participation in this conference was financially supported by the University of the Thai Chamber of Commerce and the organizing committee of the conference.

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Chapter One

HIV/AIDS Counselling: Theory and Training

1.1 Introduction

- | | | | |
|----|----------|---|---|
| ๑. | พยาบาล: | | แล้วตั้งวันนี้ (๒.๐) ↑เนาะ ((แบมือ)) |
| ๒. | | | > ช่วยเหลือตัวเองจะไคพ่อง < (.) ถ้ามีความรู้สึก |
| ๓. | | | ทางเพศขึ้นมา |
| ๔. | ผู้ป่วย: | | บ่::คายๆ ((ส่ายศีรษะ)) [ครับ |
| ๕. | พยาบาล: | | [บ่ได้ก็คั่นก่อน |
| ๖. | ผู้ป่วย: | | ครับ |
| ๗. | พยาบาล: | → | บ่ได้ ((ส่ายศีรษะ)) ช่วยเหลือตัวเอง >บ่ได้ |
| ๘. | | → | ((ส่ายศีรษะ)) ชักว่าวะหยังหนา< |
| ๙. | ผู้ป่วย: | | ครับ ((พยักหน้า)) อยู่มะคายๆ ((สัมผัสหู)) |
-
- | | | | |
|-----|----------|---|-----------------------------------|
| 1. | Nurse: | | and until nowadays (2.0) ↑right |
| 2. | | | ((stretching hand)) >how do help |
| 3. | | | yourself< (.) if have sexual |
| 4. | | | needs |
| 5. | Patient: | | no::thing ((shaking head)) [right |
| 6. | Nurse: | | [do not |
| 7. | | | think is it right? |
| 8. | Patient: | | right |
| 9. | Nurse: | → | are not ((shaking head)) helping |
| 10. | | → | yourself >are not ((shaking |
| 11. | | → | head)) wanking suchlike< |
| 12. | Patient: | | right ((nodding)) just stay |
| 13. | | | ((touching ear)) |

This excerpt from a Thai transcript is shown to illustrate some of the subjects to be covered in the introduction to this thesis, and which this study aims to address. The excerpt is extracted from an HIV/AIDS counselling session, and was transcribed with a range of linguistic symbols.¹ It shows what really happens in Thai counselling; and is interpreted as the nurse probing a male patient about

¹ See Appendix A for details of transcription conventions.

how he looked after himself regarding sexual health and pleasure. Sexuality is one of the main themes in HIV/AIDS counselling. The patient told the nurse that he had not done anything. Here, it seems to the nurse that the patient did not tell her everything. In the next turn, shown in lines 7-8 in Thai transcript or in lines 9-11 in English, the nurse uses some language techniques. The nurse confirmed the patient's claim by asking whether he did not masturbate. At the end, in the same turn, the nurse uses another technique called 'self correction in the organisation of repair in conversation' (Schegloff, Jefferson and Sacks, 1977). The nurse produced it at a quicker pace than other utterances in the same turn. In addition, the nurse applied a technique of lexical choice (Drew and Heritage, 1992, p.29-32; Drew and Sorjonen, 1997, p. 99-101 and McLeod, 2001, p.93) by replacing 'do masturbation' with a slang word 'wanking'. This was used to make the patient understand more clearly what the nurse meant. This was frequently found in HIV/AIDS counselling, particularly in the Thai context. Perhaps rather innocently, I would not have expected medical staff to ask such a question or clarify the discussion in that manner. The use of slang language and other language techniques are used in counselling in order to make talk on the many aspects surrounding HIV/AIDS successful; further details on this will be shown throughout this study. Counselling is the main focus of this study; more precisely my study is interactional and concerned with the language used in the cultural and social context of HIV/AIDS counselling in Thailand. The qualitative research method, which can be applied to this study, is *Conversation Analysis* (henceforth CA). In other words, CA is used to study the common practice of AIDS counselling in Thailand.

Before illustrating what really happens in Thai counselling, in this chapter, I introduce the background and phenomena of HIV/AIDS in the Thai context. I show the importance of counselling for patients, and discuss why HIV/AIDS patients need counselling while patients in other disease areas may not need this service. Then I illustrate the importance of HIV/AIDS and the social research conducted to try to alleviate its consequences. The focus of the rest of this chapter is the theory and practice in counselling. I illustrate the theory of counselling in which most counsellors have been trained; and compare the theory taught in training courses with aspects observed in the actual practice of counselling.

1.2 HIV/AIDS in the Thai context

UNAIDS (1998b, p.5) states that '[i]n 1984, the first visible evidence of HIV in Thailand was the diagnosis of AIDS in a man returning from overseas and receiving treatment at a hospital in Bangkok' (see also Sittitrai, Brown and Sakondhavat, 1993, p.1). 'Three years later, the importance of male-to-male sex as a risk factor was quickly overshadowed by the rapid increase in infection among injecting drug users, followed by a parallel increase in seroprevalence among female sex workers' UNAIDS (1998a, p.36). Shortly afterwards, the AIDS epidemic had spread dramatically amongst several groups of Thai people ranging from the clients of sex workers to wives and girlfriends of men who had visited sex workers.

The extent to which Thailand has been affected by HIV/AIDS is reflected in the fact that by the end of 2003, the estimated number of people living with HIV/AIDS was 570,000, 200,000 of whom were women (ages 15-49), and 12,000 of whom were children (ages 0-14).² In order to alleviate the problem, the Thai government has allocated an enormous portion of the budget to address the consequences of AIDS, both medically and socially, because AIDS goes beyond a mere health problem. The epidemic has resulted in major economic, political and social impacts.

Early on in the spread of AIDS through Thailand, as well as medical issues there were social problems with misunderstanding. In this area, AIDS severely affected Thai people and Thai culture, as is illustrated in the following statement.

'At the early stages of the epidemic, rejection of AIDS patients in community was partially caused by hospital medical procedures related to AIDS death. When a patient died at the hospital, the body was put into a plastic bag. The family was told not to perform traditional bathing rites, but to go straight ahead with cremation. Noting how strictly the hospital dealt with the corpse, villagers worried that the virus could perhaps be transmitted from the body in some way' (UNAIDS, 2000a, p 25).

² The quoted information accumulated by Global Health Reporting.org was from three sources. They are UNAIDS 2004 Report on the Global AIDS Epidemic (see UNAIDS, 2004a), UNAIDS 2004 Report on the Global AIDS Epidemic-Fact Sheets, and CIA World Factbook 2005 (see Global Health Reporting. org, 2006).

In the context of a medical setting, to some extent, the above statement might have represented the misinformation, discrimination, denial, hatred and rejection arising from HIV/AIDS at the beginning of the epidemic in Thailand. It is interesting to consider how this statement came about. One might argue that medical procedures should make patients and other concerned parties feel secure against infection with HIV. By contrast, those procedures could have been seen as exacerbating the upheavals experienced by carriers of HIV/AIDS and their relatives. One crucial social aspect resulting from these circumstances is that AIDS has been stigmatised as an incurable and infectious disease, and consequently it is usually mentioned in terms of being a death sentence. Most HIV carriers were stigmatised and rejected by communities because they were thought of in close relation to an incurable disease and imminent death. This specific definition of AIDS was adopted and it was believed that this definition was emphasized by the mass media in the early period of accepting the existence of AIDS. In this area, it can be said that the power of media content in Thailand was that the view expressed in the media bore a close relation to the public's perception of AIDS and HIV. The use of this misleading term has persisted in most Thai people and in most HIV patients since then and it has lasted for a long time. The adoption of this misleading term resulted in tremendous misunderstanding amongst Thai people, both well-educated and illiterate people. In addressing this definition and popular misconceptions, most AIDS patients became worried and anxious after having been infected with HIV because of the way in which they constructed and viewed the meaning of their death and their imagined disfigurement and dying in a way very different to other patients (see WHO, 1993 and Peräkylä, 1995). In other words, they expected to encounter impending or imminent death more so than other people. Those feelings of fear and worries might have affected the dying and death amongst AIDS patients. Cicirelli (2001, p.664) suggested this by stating:

'The personal meanings of death constructed by the individual are regarded as occurring prior to and serving as stimuli for emotional reactions'. If personal meanings associated with death have negative consequences for the individual, they can generate various death fears and concerns about dying' Cicirelli (2001, p.664).

Thus, personal meanings may influence the way in which individuals react to death and the process of dying.

Discrimination and denial caused by AIDS resulted in unemployment and lack of access to resources. There are different forms of discrimination. UNAIDS (2000b, p. 9) states that '[s]ome forms were obvious or crude (e.g. physical violence, or refusal of a particular service)'. HIV patients apparently suffered further ill-health effects because they encountered discrimination. In this area, it should be referred to as 'social death'. In other words, they were rejected by society. They might desire death prior to their natural death, which was itself considered imminent. Havanon (1997 cited in UNAIDS, 2000a, p. 24) reported that '[o]nce people realized that AIDS had come into their community, people were so frightened that they cut relationships with neighbours and friends affected by HIV/AIDS, including refusing to attend their funerals or joining in traditional community ceremonies'. At this point, it is useful to emphasise that AIDS is not only a medical concern, but also impacts on social aspects of people's lives. The interpretation of illness is related to stigmatisation, discrimination and social death. Much of the literature on AIDS indicates that HIV/AIDS has a particular interpretation that marks it out from other illnesses amongst Thai people. HIV/AIDS may be interpreted as reflecting inappropriate sexual behaviour and the assumption that patients may be promiscuous. In this area, Songwathana and Manderson (2001)³ stated that men may be regarded as brothel-goers. Some women may be regarded as having been involved with commercial sex work. In addition, victims of HIV/AIDS are associated with intravenous drug use. These actions may also be interpreted as bad behaviours which are 'taboo', and not in keeping with how normal people should conduct themselves. The same literature showed that HIV/AIDS is strongly associated with homosexuality, and the view that such groups of people may have weird sexual behaviour, and therefore 'AIDS is stigmatised as a homosexual man's punishment for his practices' (ibid, p.3).

As shown, following the dramatic spread of HIV infection, the subsequent discrimination and denial have become apparent, and are now one of the nation's

³ Songwathana and Manderson (2001) show how AIDS and the concept of stigma, vectors of disease (prostitutes), and other aspects related to stigma in Thailand. Their work clearly illustrated how Thai people interpreted this illness, and their interpretation then constituted the meaning given towards HIV/AIDS patients.

current concerns, although they were not highlighted as quickly as they should have been. At the start of the AIDS epidemic, and with respect to the economic and social impacts of the disease, many sources refer to a great deal of denial by the Thai government, which did not place AIDS at the forefront of the agenda of national concern. It was believed that the government tried to ignore the existence of this contagious disease because the acceptance and acknowledgment of its existence would have had a negative impact on growing tourism revenue (Warden, 1990, p. 415-416). Regarding this, in a direct interview with a member of medical staff who was involved with AIDS concerns, the staff member stated that the country tried to put it 'underground' in order to maintain tourism (Nilchaikovit, 2003).

In order to alleviate the consequences of HIV, scientists have tried to render this contagious disease curable. At the same time, a large amount of research was conducted in an attempt to understand the AIDS phenomenon in real world settings in co-operation with the world organisations. When AIDS became a global epidemic, UNAIDS intervened. Thailand was one of the countries in Southeast Asia, where it was regarded as having the highest numbers of HIV patients (Parry, 2001, p.10), it was inevitable that there would be intervention by UNAIDS. UNAIDS launched several programmes on HIV in Thailand after the country itself had tried to address the problem. Medical and social science research was planned and support was given for it to be carried out. In this area, it could be said that attempts were made in all sectors at tackling the AIDS crisis. A number of papers worked on the AIDS coverage, newspaper, public communication and the health messages that were distributed. Some sources believed that Thailand controlled the epidemic well because they evaluated that there was a decrease in the number of new HIV patients and the number of men who visited sex workers fell. Some campaigns on condom use were successful. They believed also that some groups amongst Thai people changed their sexual behaviour after the campaigns were launched; they used condoms more frequently when they had penetrative sex. UNAIDS (1998b, p.15) reported that 'condom use in brothels rose from roughly 10% in 1989 to over 90% by 1992'. In addition, '[i]n 1997, a survey showed that condom use amongst with girlfriends had risen to 40% and with other women to more than 60%' (UNAIDS and the Ministry of Public Health, Thailand, 2000, p. 41).

Although attempts were made to increase the awareness of AIDS amongst some sectors in Thailand, the conception and understanding of AIDS infection amongst some Thai groups were still misconstrued. Many Thai people still believed that virtually by definition, 'AIDS is fatal' (Morbidity and Mortality Weekly Report cited in Green and Green, 1987 and Williams, 1992, p.10). When it became apparent that AIDS was devastating to human life, the Thai government could no longer ignore the untimely death deriving from AIDS and the incorrect assumption at that time that this contagious disease was confined to homosexual foreigners (Karnpisit, 2000, p.39). UNAIDS (1998b, p.6) states that '[i]nfluenced by these and other epidemiological and behavioural findings, Thai society rapidly increased its response to the epidemic starting in 1991, devoting increasing resources and manpower to the effort'. Thailand has also been considered to be one of the more successful countries in grappling with the AIDS crisis (U.S. Census Bureau, 2004, p.21) and its consequences through the integration of AIDS programmes. In terms of effective implementation of initiatives to tackle AIDS, Karnpisit (2000) noted policies that were implemented throughout Thailand. Those policies resulted in much success in tackling the AIDS crisis in Thailand. AIDS campaigns and prevention advice were conducted through the use of mass media and through peer education programmes for young people. In addition, education about AIDS was introduced in schools in Thailand and there were campaigns in the workplace, in both the government and the private sector. There was a condom use campaign in prostitution and life skill training (see Karnpisit, 2000). At a micro level, in 1992 Buddhist monks in Mae Chan in Chiang Rai were trained about HIV/AIDS (United Nations Development Programme, 2001, p. 6). At the beginning, these monks did not get much involved with the issue. However, they played an important role in bringing considerable awareness of HIV/AIDS to the community. In addition, in 1994, the National Economic and Social Development Board (NESDB) in collaboration with various Thai and international partners prepared projections for the impact of HIV and AIDS in Thailand (Department of Communicable Disease Control, 2001, p.1). These represent to some extent how Thai people and Thai government were spurred by AIDS to utilise strong cooperation.

However the efforts to control the AIDS epidemic in Thailand have not been consistent because the infection situation has been changing over the years.

UNAIDS (2004a, p.28) states that ‘HIV is now spreading largely amongst the spouses and partners of clients of sex workers and amongst marginalized sections of the population, such as injecting drug users and migrants’. In addition, it also shows that men who have sex with men have become another group particularly at risk. UNAIDS points out that ‘[i]n Bangkok, over 15% of men who have sex with men who were tested in a 2003 study were HIV positive, and 21% had not used a condom with their last casual partner’ (ibid). This is because ‘these men are often faced with the added risk associated with anal sex, which is more likely to result in HIV transmission than vaginal sex, unless condoms are correctly used’ (The Monitoring the AIDS Pandemic, 2004, p. 4). Great effort had been still made to ease other consequences of AIDS; social research was simultaneously supported to find out how people interpreted this disease. Most of the results of the research were expected to be used for strategic planning so as to enhance proper understanding in the Thai people of real-world experiences of AIDS. From the outset, the national response to AIDS and its consequences had been to push for prevention. Several campaigns on condom use were thus launched in Thailand. Some programmes were initiated with the specific intention of changing the sexual behaviours of people who were believed as a group to be at high risk. In this area, most of the research was supported by the Thai government and other related off-shore organisations in the hope that prevention could be achieved.

A number of studies in communication research in Thailand were based on cultural approaches for AIDS prevention and care, and the promotion of condom use, and also on how people living with AIDS could exist within their families and communities. The country report ‘A cultural approach to HIV/AIDS prevention and care’ by Viddhanaphuti (1999) illustrates the cultural construction of HIV/AIDS. It showed that since AIDS appeared in Thailand in 1984, AIDS had been constructed in three negative cultural images; AIDS: a moral laxity, people with AIDS as dangerous others and AIDS as an individual’s problem or a risk group which deviates from the society’s norm. These cultural deconstructions led to people with HIV being pushed underground. However, after they had started mobilizing, they learned how to disclose themselves within groups. This led to a new identity of HIV patients and the group’s disclosure to the public. This report revealed a positive approach to dealing with the problems

of people with AIDS. It was also shown how some patients revealed their infection to the public while maintaining equal employment, and how they established a caring community including how they developed new social relationships within the village. In addition it was shown how patients developed their social relationships with the wider population outside their own village (ibid). All of this has been carried out by means of a cultural approach.

As well as the above example, a number of social research studies were carried out for the purpose of finding out how people could live with HIV, as this is one of the popular concerns surrounding the AIDS crisis. In several countries, families and communities play an important role in the care and support of HIV patients. Similarly, the study 'Care and support for people living with HIV/AIDS in northern Thailand: findings from an in-depth qualitative study' by Singhanetra-Renard, Chongsatitmun and Aggleton (2001) was carried out to illustrate how communities and families were important to AIDS patients. Care for HIV patients in Thai families is most typically provided by the mothers and the wives of patients. This study underlined the fact that carers would encounter a number of burdens after a patient's death such as an economic crisis. Cases were found where elderly people had to raise and care for their orphaned grandchildren. In addition, the study indicated that people with HIV were reluctant to access formal health care until they were in the last stage of infection. This study suggested that better co-ordination was required between formal health care providers, which included formal care in local hospitals and polyclinics and care provided at the household and community levels (ibid).

The work of Knodel and Saengtienchai (2002) on 'AIDS and older persons: the view from Thailand' revealed that patients parents were the primary carers in Thailand. AIDS patients have imposed a tremendous burden on the health care system. This report showed that parents played an important role in connection with the health care system. For example, they provided appropriate treatments or administered the prescribed medications, and consequently some programmes on AIDS care and support should be designed for those patient's parents. Furthermore, carers should be trained to handle the associated economic hardships, such as the limited budgets for taking care of patients and fostering orphaned grandchildren after AIDS patients had died. In addition, the cultural context and setting should be considered when any programme on AIDS is

implemented. This is because Thailand has its own cultural setting, which is strongly influenced by its heritage of Theravada Buddhism. These specific cultural settings result in causes and consequences of the AIDS epidemic (ibid).

In addition, another social research study entitled 'Perceptions of HIV/AIDS and caring for people with terminal AIDS in southern Thailand' by Songwathana and Manderson (1998) illustrated communication in counselling. This study revealed that the contemporary perception of AIDS was still negative. Indeed, although people had been taught awareness of AIDS, they misunderstood the circumstances of HIV transmission through social contact and provision of care. It was also shown that various sources such as the mass media contributed to a sense of fear, danger and risk from AIDS by portraying it in a negative way (ibid, p.S164). At the same time, it also showed that the best sources of information about HIV and AIDS were physicians or other health professionals rather than the print media because of the unclear messages and one-way communication which characterises the media. This research also pointed out that health service providers improved their own understanding of HIV/AIDS in order to be able to provide appropriate medical attention and advice, but also to be able to offer emotional support to patients. It also suggested that HIV/AIDS counselling should be encouraged and be accessible in rural areas (ibid).

The importance of counselling is referred to in the work of Müller et al. (1995). Their work, entitled 'Sexual risk behaviour reduction associated with voluntary HIV counselling and testing in HIV infected patients in Thailand', points out that voluntary HIV counselling and testing (VCT) could be considered a complementary approach in contributing to the reduction of HIV transmission in Thailand and other Asian countries. Within this study, a controlled cross-sectional design was used to study the associations between HIV-VCT and sexual behaviour in Thailand (ibid).

In summary, social research undertaken to grapple with AIDS can be divided into three groups for the purpose of prevention; to provide care and support; to dispel discrimination. While attempts have been made for alleviation of AIDS, counselling on HIV/AIDS has emerged as the principal tool to cope with the complexity of this disease.

1.3 HIV/AIDS Counselling

In keeping with other countries, the way to deal with HIV patients is to bring awareness and understanding of AIDS, dispel any discrimination and ideally encourage most patients towards the concept of this illness. These issues are rendered important through the discourse of health policy in certain areas in Thailand. HIV patients are provided for and ensured access to some resources. When someone is infected with HIV, he or she is expected to apply for a health consultation at a hospital or public health office. Counselling for HIV/AIDS can be seen here as one of the resources, in the form of a service, which patients can gain access to. In this area, Peräkylä (1995, p.2) points out that '[o]ne of the social responses to the HIV epidemic has been the setting-up of counselling services for the people whose lives have been touched by HIV and AIDS'. Regarding the definition of AIDS counselling, the Global Programme on AIDS (GPA) of the World Health Organization (WHO) defines HIV/AIDS counselling as 'a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS' (WHO, 1995, p.1). Burnard (1997, p.99) states that '[c]ounselling is the process of sitting and talking to a client, patient or colleague with the intention of helping them to arrive at decisions about how to act'. WHO (op.cit.) also states that '[t]he counselling process includes an evaluation of the personal risk of HIV transmission and facilitation of preventive behaviour'. In short, WHO (1994a, p.27) points out that '[i]n counselling, two people who are in no way related to each other meet to resolve a crisis, solve a problem, or make decisions involving highly personal and intimate matters and behaviour'. At this stage, counselling is interaction. In HIV/AIDS counselling there are two main goals, first, 'to give psychological support to those whose lives have been affected by HIV'; and second, 'to prevent HIV infection and its transmission to other people' (WHO, 1994b, p.2). Bor and Miller (1988, p.389) stated that 'AIDS counselling in a clinical setting may be viewed as the use of co-ordinated medical, psychological, educational and psychiatric techniques to assist people to make a better adjustment to their social and emotional environment'. Counselling encourages the patient to recognise what really concerns the patient. In counselling, an

appropriate way to resolve problems is mutually found by the counsellor and the patient. The HIV patient is expected to seek out counselling more readily than patients with other diseases because an HIV patient might adopt a concept of social death formed by himself, herself and others. In addition, it is believed that an HIV patient needs confidentiality and privacy in relieving stress and worries which might lead the patient to terminate their life in an inappropriate and untimely way. At this point, it can be said that the counsellor is regarded as a confidant to whom the patient may want to turn. Importantly, patients should be counselled about social responsibility because this disease is contagious. This may mean that counselling is conducted, in part, to control the spread of disease. Counselling thus is important to patients themselves and to others who have contact with them. However, although counselling is important, conducting a proper counselling is not easy. Bor, Miller and Goldman (1992, p.4) show that '[c]ounselling is not a process of doing something for someone. [i]t is best defined as an interaction between counsellor and the patient'. Counselling thus is conducted by talking. Talking to a counsellor as a stranger about personal matters such as confidentiality, worries, death, illness, or sexual conduct seems not to be a normal practice in Thai culture. Counsellors and patients are engaged to discuss important aspects emerging from infection. Counselling sessions are usually accomplished by means of language and communication in order to aid the patient's comprehension of each session. Questions and answers (Q&A) are seen as central features of counselling. Questions and answers taken in turn between the nurses and the HIV patients, and are not produced in a vacuum, but they are moulded based on 'the context'. This context refers to the backgrounds of the nurses and patients. In other words, the context of the nurses refers to their experiences and orientations in their settings. For the patients, the context refers mainly to their experiences.

Counselling in the context of HIV/AIDS may be conducted by psychologists, social workers, religious leaders or health care professionals. As in other medical settings, Thai counselling sessions are accomplished by health care professionals-mostly nurses because '[m]any health care professionals have a primary training in medicine, nursing physiotherapy or other allied professions' (Bor, Miller and Goldman, 1992, p.3). However, not all are entitled to do such work because counselling with HIV-positive patients is different from

counselling with other diseases. Conducting proper HIV/AIDS counselling sessions according to the goals stated by WHO is remarkably difficult. AIDS is a special disease and it is associated with social aspects such as stigmatisation. Green and Green (1992, p.232) state that '[c]ounselling for newly-diagnosed AIDS patients must be optimistic and counsellors must try and be positive in their attitudes'. Nord (1996, p. 406) stresses the importance of knowledge in counselling by stating that '[c]ounseling the survivors of multiple losses requires a good foundation of knowledge in the treatment of complicated bereavement and trauma'. Importantly, counselling is conducted by talk-in-interaction.⁴ Persons who wish to be counsellors are required to have a specific training in the area of AIDS, which they can apply to such a stressful kind of job. Burnard (1992, p.17) stated that AIDS counselling is other kinds of counselling which nurses who undertake such counselling usually have special training.

Counsellors are expected to be trained on a formal counselling course, or at least on a basic counselling course because the medical knowledge which most nurses have might not be sufficient to cope with some special problems that arise in the context of HIV/AIDS. Miller and Bor (1991, p.1) point out '[c]ounselling is important in AIDS and HIV infection because: [t]here is no cure, AIDS is almost always fatal'. In addition, they also point out that 'HIV is infectious, those most at risk are the young'. Being HIV-positive may bring about social and health problems. Bor and Miller (1988) and George (1989) show that patients are concerned with their illness, disfigurement and death (see Peräkylä, 1995, p.4). Having been trained on one counselling course, nurses are expected to conduct interaction related to three main areas: prevention, living with infection and control of the spread of infection. In addition, training also encourages counsellors themselves to be able to cope with their stress and burnout from HIV/AIDS. This means that nurses learn the particular theoretical knowledge required to cope with their patients and with the stress imposed on them at the same time. Theoretical knowledge is expected to be applied extensively during a health consultation with the patients in pre-test counselling, breaking the news and post-test counselling.

In training, most HIV/AIDS counselling content originates from manuals

⁴ See Schegloff (1987), and Boden and Zimmerman (1991, p.8) for further description of talk-in-interaction.

from the WHO global programme on AIDS.⁵ These manuals with specific knowledge are distributed in most countries where there is considered to be a high risk of an HIV epidemic and where there are a large number of HIV patients. Within these countries, for example Thailand, the governmental offices will take charge of this matter. The Thai Ministry of Public Health adopted the manuals for use in the Thai medical context.

Although HIV/AIDS counselling is important, little attention is paid to how knowledge of counselling and counselling as interaction is conducted in the Thai context. However, there have been some studies of counselling conducted, though only in the context of the evaluation of counselling. For example, evaluation of voluntary counselling and testing in the national prevention of mother to child transmission program⁶ was conducted by the Thai Ministry of Public Health in cooperation with UNAIDS and WHO (see the Ministry of Public Health, WHO, and UNAIDS, 2000). The ultimate aim of this programme was to evaluate the counselling. This study was conducted by distributing more than 10 sets of questionnaires amongst concerned parties, such as counsellors and patients. Importantly, the questions in the research tools were adjusted from guidelines issued by UNAIDS.⁷ The study results showed an overview alongside statistics for each aspect, such as an evaluation of counsellors in terms of communicating information, work on family planning, and burnout due to stress. Patients were asked about their satisfaction with the services they received from medical staff. Hitherto no research been carried out, in the Thai context, with the purpose of investigating how such health consultations are accomplished by means of a particular methodology, which can apply to any talk about health between two parties. In other words, no attempt has been made to explore how people engage in talking on something very significant for their lives. Counselling and the language used between the nurses and patients is the main theme of this study.

⁵ A psychiatrist who is involved with AIDS counselling in Thailand noted that WHO's guidelines were broad and easy to be applied in different cultural contexts. As I had revised WHO's guidelines, I found that those were not built up in a specific knowledge context as applied in counselling of some countries such as in Italy or UK.

⁶ This programme was launched in July 2000, but the publication referred to in this study was in 2001.

⁷ Questions in the research tools for this programme were adjusted from UNAIDS's document titled 'Tools for Evaluating HIV Voluntary Counselling and Testing' (see UNAIDS, 2000c).

In the Thai setting, although the theoretical knowledge of counsellors has been regarded as crucial for the counselling job, never before has research into counselling been carried out so as to disclose how theoretical knowledge is accomplished in conducting a health consultation. What I wish to investigate throughout this study is not aimed at evaluating counselling or how counsellors learn their knowledge and theory, but instead is related to the knowledge applied in counselling. This research aims to reveal how counselling as interaction is conducted. Thus, I will look at how the counselling appears in practice by first looking at the structure of counselling. Then, I explore what themes have been discussed in sessions, and how the theoretical knowledge of the counselling nurses has been used throughout the natural social interaction in the medical institutional setting. Specifically, this research underlines how the theoretical knowledge of the nurses was used during the post-test counselling⁸ by analysing their talk in the particular structure of counselling.

In summary, counselling is a tool for AIDS alleviation. Conducting proper counselling cannot be done by general nursing or medicines, but needs a specific knowledge of HIV/AIDS. Before I investigate the theoretical knowledge of the counsellor in counselling, we should know what counsellors learn. They must attend at least one basic counselling course before they can perform a counselling job. The next section outlines the training that each nurse receives; the counselling course provides a foundation for skills, which most counsellors apply to their task. The next section also shows the role of theory in determining the place of counsellors in the social order. After describing counselling theory in detail, I set out the research questions informing the study as a whole.

1.4 The background of HIV/AIDS counselling theory

In Thailand, the main counselling guidelines were provided by the Department of Mental Health under the Thai Ministry of Public Health. This office took the

⁸ WHO (1994b, p.39) states that '[p]ost-test counselling is a dialogue between a client and a care provider aimed at discussing the HIV test result and providing appropriate information, support and referrals, and at encouraging risk-reduction behaviours'.

guidelines laid out by WHO and adjusted them for use in a Thai setting. Most of the content and themes were adjusted appropriately to fit the social structure, age range, gender distribution and educational level in each (e.g. provincial) context in Thailand. When the AIDS epidemic was spreading dramatically in Thailand, a large number of counsellors were required suddenly and urgently. Thus, the training courses were developed with this urgency in mind. In the past, counselling courses had been taught in universities and colleges for psychiatric and psychological students or some other social science students. Students were required to spend a year or more on learning the skills required. Counselling courses were quickly condensed into very short versions, which were believed to be appropriate for the critical period of the spread of AIDS (Department of Mental Health, 1996, p.1). At the outset, Barry (1994) who was involved with counselling, prepared some training handbooks for counselling skills. His works played an important role in bringing awareness of counselling to the Thai context. At the beginning, most of the AIDS counselling courses lasted 5 days. Over a period of time, the general AIDS counselling courses were gradually improved and other related courses were initiated such as courses on counselling for death and dying. Most of the counselling courses were held by the Thai Ministry of Public Health and other offices under its administration.

Before describing the counselling theory in which the counsellors should be trained, I should elaborate where and what I learnt about such theory. It may be useful, at this stage, to illustrate the training courses in which I participated during the field work.⁹ These courses provided the nurses with the foundations of their theoretical knowledge. There were two AIDS counselling courses, the first of which was organised by an office under the administration of the Thai Ministry of Public Health. This office was in the Nakhon Sawan province, which was in the south of the northern part of Thailand. The aim of this 4 day course was to provide all participants with the knowledge to become counselling trainers. I participated in this training course as an observer. In addition to this 4 day training course, I also participated in AIDS counselling held by non-governmental AIDS organisations in Bangkok. This second course was held for two days in March and two days in April at a hotel in Bangkok. This course was

⁹ In chapter two, I illustrate the way in which I approached these training courses and what I learnt from them.

designed for volunteers who had applied for a hotline counselling role in the organisation. At the end of training, they would be assessed by the organisation as to whether they were suitable to be a counsellor or not. In the next chapter, I illustrate how I obtained access to these training courses.

Participants were given theoretical and practical training: they were trained through classroom lectures, group discussions, small group activity, role-play and games. They were also provided with examples of counselling on video however, the participants in those example sessions were actors.

1.5 Overview of HIV/AIDS counselling skill training

Both counselling courses began by introducing participants to three key subjects: the qualities required to be a good counsellor, the basic skills of a counsellor and the core steps of counselling. Next important theoretical knowledge, such as techniques for using questions and answers, was taught. Here, I will expand on these four subjects, based on my participation in both counselling courses and the guidelines provided by WHO.

1.5.1 Qualities of a good counsellor

A guide for trainers from WHO called ‘an orientation to HIV/AIDS counselling: a Guide for Trainers’ illustrates the qualities of a good counsellor (see WHO 1994a). The essential qualities of a good counsellor include being (1) positive in regard to or respect for people, (2) open, non/judgemental and in possession of a high level of acceptance, (3) caring and empathic, (4) self-aware and self-disciplined, (5) knowledgeable/informed about the subject and aware of the resources available within the community, (6) culturally sensitive, (7) patient and a good listener, (8) able to maintain confidentiality, and (9) objective and having clarity of reason (see WHO, *ibid*).

1.5.2 Basic skills of a counsellor

WHO (1995, p.8) states that ‘the basic skill involved in HIV/AIDS counselling is personalized one-to-one communication relying heavily upon conversational and listening skills’. During the training course held by the Thai Ministry of Public Health, all participants were informed about these basic skills. They were told that they should be concerned with (1) active listening, (2) effective questioning, (3) observation, (4) silence, (4) restating important information, (5) encouragement, (6) reflection, and (7) summarising.

1.5.3 Core steps of doing counselling

If one asks a counselling nurse about their training, she or he may refer to remembering the basic knowledge by reference to a ‘v’ or ‘u’ shape. Every time there are counselling courses, the core steps of doing counselling are reiterated. They are usually mentioned at the start of any counselling course. Described as either ‘v’ or ‘u’ shaped, they consist of 5 essential stages, and they are (1) Forming rapport and gaining the client’s trust, (2) Definition and understanding of the roles, boundaries and needs, (3) Provision of information and selection of realistic alternative resources, (4) Process of ongoing, supportive counselling, (5) Closure or ending the counselling relationships. These five stages of counselling are slightly different from the 4 stages of WHO’s approach because an additional stage of provision of information and selection of realistic alternative resources was added for counselling in the Thai context. At this stage, it is useful to illustrate each stage in brief.

Forming rapport and gaining the client’s trust: Occasionally, a counsellor must spend time building rapport and gaining the client’s trust. This is important because it leads to the client’s continued trust and involvement with counselling.

Definition and understanding of roles, boundaries and needs: Counsellors are expected to be able to clarify the patients’ needs, concerns and goals and identify a priority order amongst them.

Provision of information and selection of realistic alternative resources: Counsellors have to provide adequate information for patients. This can

encourage patients to assess their concerns and needs and select possible solutions.

Process of ongoing, supportive counselling: Ongoing counselling focuses on enabling the client to take charge of their own situation and move towards change. A counsellor teaches his or her patient to plan for the future and think about issues that will be important in the long run. This stage includes encouraging the client to express his or her emotions, such as fear and anger.

Closure or ending the counselling relationships: This stage can be implemented when a counsellor learns that his or her patient can be independent and can cope alone and adequately plan for day-to-day functioning.

1.6 Specific skill

Miller and Bor (1991, p.1) state that '[t]here are many ways of counselling, and each depends on the background of the professional and the nature of problem'. Thus, each area has adopted an appropriate way to apply in its context. For example, the work of Bor and Miller (1988), referred to as the 'Milan Approach' in family therapy, is the main theoretical approach applied to a health consultation. The work conducted by Peräkylä (1995), the Family Systems Theory¹⁰, is the main theoretical approach used in counselling. AIDS counselling in the Thai context has no specific theoretical approach and is different in comparison to the work of both Peräkylä and the work of Bor and Miller. Counselling should ideally be achieved by integrating general theoretical knowledge gained from training with the experience and knowledge of counsellors in each particular setting. The particular setting refers to the 'context' in which the counselling takes place, in terms of the location, type of patient and reason for counselling. Most counselling nurses are trained to be client-centred. In other words, most counselling nurses should undertake their counselling job using their theoretical knowledge, but how they apply that knowledge in their talk with patients depends on the varied context of what each patient needs to talk

¹⁰ Peräkylä (1995) gave details of Family Systems Theory in his work on AIDS Counselling. The focus of Family Systems Theory is primarily on understanding family relationships.

about because each patient has his or her own emotions, anxieties and worries. They also have different physical and mental needs.¹¹

In most training courses, as noted earlier, most nurses were taught to be client-centred. In other words, they were taught to pay attention to the patients and concentrate on what concerned them. The nurses should be concerned with the 'v' or 'u' shaped of the 5 core steps of counselling. Theoretical knowledge was usually communicated to the nurses in the form of lectures, round-tables, work shops, role-play, case studies and group discussion. Video and audio presentations were used for practising. During the training, the nurses also took part in some leisure activities. Importantly, they had to take turns in assessing what they had just learned, and practise on one another in particular activities.

Counselling skills: Counsellors must be trained in real and practical counselling skills. WHO (1994b, p.28) states that 'counselling always involves communicating about sensitive issues, and it differs from advising; counsellors should develop the skills of active listening, encouragement, recognising acknowledging, effective questioning, empathizing, respecting, clarifying, paraphrasing, connecting, challenging, repeating, emphasizing, making action plans, structuring, motivating and summarizing'. However, during the two training courses, some skills in particular were underlined. They were active listening, encouragement, effective questioning, empathizing, paraphrasing and summarising.

Active listening: Burnard (1990, p.98) and Burnard and Kendrick (1998, p.37-41) points out that 'to listen to another person is the most human of actions, and in counselling listening is the crucial skill'. The counsellor was trained to employ verbal utterances, gaze and gestures in a session to indicate that he or she understood what the client said and, what was conveyed.

Encouragement: In counselling, encouragement performs two duties. The first is to literally encourage or support the patient. The second meaning is a way of answering a question. It is used to respond to a question by the patient. In this manner, encouragement means that the counsellor should encourage the patient to express their feelings. This is because in some cultures people, and therefore

¹¹ Burnard (1992) stated that the patient-centred approach was first used in 1951 by Carl Rogers. It refers to the notion that 'it is the client himself who is best able to decide how to find the solutions to his problems in living' (Burnard, 1992, p.48).

patients, are taught not to express feelings openly, even though they may feel something deeply.

Effective questioning: Asking and answering questions can be seen as the central feature of the method for conducting counselling. At this stage, I focus on how the nurses were taught about the use of effective questions. As well as asking questions, the nurse sometimes acts as an answerer. In this section, the types of questions and answers and how such questions and answers questions are used are illustrated side by side.

Question: There are many kinds of question which can be used to obtain relevant information from the patient. However, the way in which each question is used depends on the situation.

Close ended question: Close ended questions can be used when a counsellor needs a specific answer. In addition, using a close ended question can allow a counsellor to confirm that the patient's perception is the same as that held by the counsellor. Close ended questions will be used when a counsellor needs to make a decision. However, mostly, the nurses were told to avoid using close ended questions because most patients should be encouraged to express their concerns freely.

Open ended question: Participants were directed to use open ended questions during a health consultation because using open-ended questions could encourage patients to talk about their concerns and worries. The aims of using open ended question was to give patients an opportunity to speak about their experiences and express their feelings. Open ended questions were used to give the clients a number of alternatives for how to respond. Using this kind of question also provided an opportunity to be able to answer freely. For example, during the training courses, participants were given two sentences 'What else?' and 'what else sir?' The second is considered to be close ended, and is a type of question which should not be used. This is because it could block the conversation. In addition, participants were directed to avoid any questions which would lead to a simple 'yes' or 'no' response.

Leading questions: During the training, participants were usually told by the speakers that leading questions were to be avoided because the patients might not answer in a natural manner. They should feel free to answer in whatever way they wanted to provide information to the counsellors. In other words, the use of

leading questions might lead counsellors to influence the answers provided.

Non-judgemental questions: Participants were oriented to avoid any questions which contained judgemental implications because patients can feel that 'they are being blamed'. An example can be given to illustrate this. When a counsellor expects her patient to use a condom, she should use the sentence 'Using a condom would be better right?' instead of 'why don't you use a condom?' In short, a question which begins with 'why' might lead some patients to feel they are being blamed.

Answer question: In answering questions, the nurses were trained in several alternatives, according to the situations which they encountered.

Encouragement: Encouragement in this context could be seen as one method of answering questions. They practised encouraging patients. Participants had to get in touch with the emotions and feelings of the patients, and to find the potential of patients in order to effectively realise such potential. There was a pattern for encouragement; it begins with a negative, then a positive, and ends with subsequence. For example, counsellors can say: 'Although you feel very ill, you are still strong, I really appreciate your good parenting.'

Euphemism: Euphemism or restating information is vital when a counsellor has to encourage his or her patient. Single direct sentences could mean many different things to different people, and might appear negative to some patients. Thus counsellors were trained to avoid using such sentences, and at the same time taught about other sentences or utterances that could be used to replace them. In this realm, one example can be given. Whenever a counsellor has to dispel someone's anxiety on death and dying, she or he had to avoid the repetition of the dreaded word, and instead it should be replaced by another in the sentence. For example, 'you are not dead' can be replaced by 'you are alive'.

Inform and explain: One feature of answering questions is to explain. Some patients might have some difficulties in understanding the information the nurses had given them. Thus, one way to make the talk clearer is to explain using examples, such as when a counsellor has to explain how the body's immune system can be damaged by HIV. This also includes giving information and suggestions.

Silence skills: Silence skills are referred to where there is no verbal communication delivered by the counsellor at some points during the

consultation. In this area, participants were informed that they should try to comprehend when they should talk and what they should talk about. At the same time, they should apply silence skills during a consultation. The application of silence to a consultation is to allow a patient to think, identify and compile the detail of issues. In addition, one aim of this application is to prepare for proceeding to the next issue. Occasionally, a patient might not need to talk, consequently a counsellor could support them by using silence. Importantly, this silence skill should be applied after an expression of emotional feeling, such as a patient crying.

Repetition: a way to evaluate patients. Occasionally, counsellors need to evaluate their patients. Thus they might ask their patients to repeat some aspects of the consultation. Repetition is one of the methods for evaluating each patient's understanding by restating and repeating the methods and information provided.

Empathizing: The counsellor was trained to be empathetic. WHO (1994b, p.28) states that '[a]lthough counsellor should empathize, they should control their own emotion'. In addition, WHO (ibid) also states that '[c]ounsellors should find a correct balance between detachment and closeness in order to promote the autonomy and problem-solving skills of the client'. The counsellor should not make an attempt to place himself or herself in a patient's situation. This is because it may be stressful to the counsellor and might lead to them burning out. Occasionally, when some counselling nurses expressed sympathy rather than empathy, they may experience some stress. At the same time, they might experience burn out from doing this stressful kind of job. Consequently, they were provided with skills to cope with this. During the counselling training courses, some attention was paid to the nurses in the context of their potential burn out. They were told to stop doing the counselling job when they felt too stressful. They might then have to seek a consultation either with their colleagues or their close friends.

Paraphrasing: Paraphrasing can be used when the counsellor wishes to repeat what the client said using different words. This technique is used to make the patient feel that he or she is understood by the counsellor, and that the counsellor is paying attention to the patient. The use of paraphrasing can help the nurse maintain distance from taking sides on a matter of concern to a patient.

Summarizing: Summarizing is used to help ensure that the counsellor and

patient understand the same thing correctly. The counsellor should review the important points of the discussion and underline issues of considerable concern to the patient. The nurse was also told during training what counselling should not include, in other words, what he or she as a counsellor should avoid. These are 'giving advice, making decisions on behalf of clients, judging clients, interrogating clients, blaming clients, preaching or lecturing to clients, making promises that the counsellor cannot keep, imposing the counsellor's belief on clients and arguing with patients' (Southern African AIDS Trust, 2001, p.2).

Last, the nurse was told about the referral system. The referral system is designed to support the counsellor if his or her task goes beyond counselling. During the training, the participants were trained to prepare a list of other relevant organisations, which can support patients by other means, such as funds or scholarships. Counsellors were told not to get involved with this kind of service.

1.7 Research question

Having shown the background of the HIV/AIDS phenomena and counselling theory, the research questions of this study should be set out here. This study aims to investigate social interaction between the nurse and patient in three main aspects described in the research questions below.

The first research question is 'what is the structure of HIV/AIDS counselling?'

The second research question is 'what actually happens in the practice of counselling?'; more precisely what themes or issues are considered in counselling encounters, and how have these themes or angles have been brought up for discussion?

Third, nurses have been trained in theoretical knowledge. Thus, this study aims to reveal how such knowledge is actually applied in counselling practice. This research question is not determined by my own knowledge. I have been inspired by the work of Peräkylä (1995). In his work on AIDS counselling (1995, p.337), he recommended that further counselling research should be conducted to explore how theoretical knowledge is applied in sessions.

I began this chapter by illustrating the background of the AIDS epidemic in Thailand. Following this, I showed how Thai society attempted to tackle its consequences. Counselling is an important task lying behind this attempt, aimed at bringing awareness to communities and people living with AIDS. However, little attention was given to research into counselling. This then inspired me to investigate the counselling in my own research. Throughout this study, I illustrate what really happens in counselling sessions. At this point, I should demonstrate how this study is organized, as shown in the following section.

1.8 Organisation

This study is divided into nine chapters. I have described the AIDS phenomenon in Thailand and the importance of HIV/AIDS counselling in this chapter. Here, I demonstrate the organisation of the remainder of this study by showing the main themes of each chapter as follows.

Chapter Two describes the field research context. This chapter focuses on three main aspects. It describes the gaining of access and how I built up relationships with research participants, and the institutional setting of the local hospitals where the data were collected. In addition, the researcher's characteristics and impact on field work and the activities of the researcher are shown. Last, formal and informal activities in the research site are illustrated.

Chapter Three describes the data collection and methodology. This chapter reports how data were collected. The main mode of data collection-the recording of naturally occurring interaction-is demonstrated. This chapter also illustrates details of the methodology of Conversation Analysis and the important reasons as to why this methodology can be practically applied to counselling in the Thai context. This methodology is explained and its special characteristics are shown.

Chapter Four outlines HIV/AIDS counselling in practice. This chapter illustrates what the counselling observed in the field work looks like. Importantly, this chapter briefly shows a case in which most areas of counselling were exemplified.

Chapters five through eight contain the data analysis. Typically, each chapter shows the initiator of the topic. In addition, I illustrate the way in which the initiator brings the topic up, and what co-participants discuss in each theme. In some chapters such as chapters seven and eight, the structure of sexual talk and death talk are illustrated.

Chapter Five concentrates on the participation in the programme of antiretroviral drugs and selecting for this programme. This chapter shows that patients may encounter risk and dilemma if they participate in the programme.

Chapter Six looks at disclosure and confidentiality. This chapter shows how confidentiality concerns most patients. Patients decide who should know or not know their infection.

Chapter Seven gives details of sexuality in counselling. This chapter shows an aspect of sexual talk and the way in which the nurse and patient initiate the topic of concern. In addition, how the topic is managed, and the pathway of talking about sexual conduct are illustrated.

Chapter Eight focuses on the prospect of death. This chapter shows how the counsellor engages her patient in talking about aspects of death, their future, and prepare her patient for the prospect of dying and death. Importantly, this chapter shows the stages of talking about death, and how the delicacy and awkwardness in each stage is managed.

Chapter Nine is the concluding discussion. This chapter starts by showing contributions offered by this study to AIDS in Thailand. In addition, I show contributions to HIV/AIDS counselling in Thailand and in general, the use of methodology of CA, and the access to data. Following these, this chapter answers the research questions as the main findings. It then illustrates the practical implications and future directions emerging from this study.

1.9 Conclusion

In the first section, this chapter focused on HIV/AIDS in the Thai context and aimed to show how it was perceived when it was first introduced to the Thai people. The Thai people and government came to terms with the existence of this

contagious disease, and this influenced the efforts to tackle its serious consequences by involvement with international organisations. This chapter illustrated the importance of social research, especially communication research, as part of the social research aimed at alleviating the burden of AIDS. Social research covered the importance of counselling between the nurses and patients in particular areas which can be investigated, for example the area of the language and communication used during talk can be examined by a methodology for fine grained analysis-conversation analysis. Second, the chapter addressed the origin of HIV/AIDS counselling. HIV/AIDS counselling in Thailand was guided by the WHO guidelines, and it was later adjusted as appropriate for Thai cultural and social aspects. Patient-centeredness was the main theoretical approach applied in Thai counselling. At the end of the chapter, the research questions were set out. This study focused on the structure of counselling, what has been discussed in counselling sessions, and how the theoretical knowledge is applied in counselling.

The next chapter will illustrate the settings in which the field research took place. Within it, three main aspects of the research will be described: notably gaining access and field relationship; the researcher's characteristic and impact on field work, and the researcher's activities.

Chapter Two

The Field Research Context

2.1 Introduction

Hunter (2005 p.8) pointed out that '[t]he most important terrorist movement in the world today is not al Qaeda but a disease whose name we are just as tired of hearing about: HIV/AIDS'. HIV/AIDS is thus global power. During the last 30-40 years, in Thailand, the political scene underlying this study was believed to be threatened by a crisis of communism. For years, some medical staff as opinion leaders played a paramount role in tackling the political crisis. In more recent times, they have fought in cooperation against a terrorist or monster that is AIDS. The research site where this study was conducted has been jeopardised by AIDS. It represents many things to me as a researcher because it acted as a school in which I learnt many things about the phenomenon of AIDS in the context of a hospital and a community. Residing in the research site shaped my understanding and reshaped my thoughts towards AIDS in a Thai community. More importantly, the research site was the place for the main mode of data collection: the recording of consultations. Consequently, the field research context should be illustrated.

This chapter aims to describe and analyse three main aspects relating to the research site. First, I will show how I gained access to the research setting in order to study the AIDS phenomenon and record consultations. I show how I built up relationships with nurses and patients. Second, the researcher's characteristics and impact on the field work is shown. Last, I will illustrate formal and informal activities in which I was involved in the research site.

2.2 Access and field relationship

One of the major concerns of social researchers is the matter of one's entry to a research site. Gaining access may be difficult; more so where the research is concerned with sensitivity and confidentiality. Corbetta (2003, p.244) illustrates how '[g]aining access to the study environment is probably one of the most difficult tasks in participant observation'. This statement is true of my first attempt at access. However, access was gained at my second attempt. Soon afterwards, I was introduced to the medical staff by the director of the first hospital, and I began my work as a fieldworker in the research setting.

2.2.1 Gaining access

It was rather difficult to gain access to the field site because my study used a unique technique for data collection: I recorded consultations on video. This was regarded as a new thing in the Thai research communities. In addition, my study was concerned with sensitivity and confidentiality of people's life. In finding a field site, I utilised two types of application to gain access to data. The first type proved to be difficult and unsuccessful, and it was refused. By contrast, the second method for gaining access was quite successful. At this stage, it is reasonable to say that this was the critical point in the progress of my research; I was able to gather data recording counselling sessions and become involved with several further activities beyond my original expectation.

First application for data access: a lesson learned in traditional field research: Having sent a formal letter along with relevant documents such as a statement of research, protection of confidentiality agreement, consent forms for patients and consent forms for health care professionals both in Thai and English to the first area, I was told informally that access to data was refused. I had chosen this area for data collection because I knew one nurse. The main reason for this may have been because the subject of this study is a sensitive topic. As a stranger I was requesting to be included in the confidentiality of HIV patients and medical staff. Lee (1993, p.121) shows what the researcher may encounter in the fieldwork by stating that '[t]hus it is difficult to avoid the fear of being a stranger,

the fear of rejection when seeking personal details about people's lives, and the fear of violating the normative standards of those being studied'. Extreme care is thus required at every stage in order to carry out this socially sensitive research. Despite many attempts to explain my care and knowledge of the sensitivities involved, through the use of documents and interpersonal communication, my first attempt at data access was not successful. I had called the non-medical gate keeper from the United Kingdom to negotiate access to data. I had informed her of the terms of the confidentiality, the protection of right applied to this research, unobtrusive observation and non-interference in the activities of the hospitals. The gate keeper had some comments and recommendations on the media used for data collection. In this area, although my proposal was refused, I did not give up my aim to conduct this sensitive research through a new methodology with such novel data collection methods. In my opinion, the access was also rejected because the gate keeper was not a member of the medical staff, and consequently did not completely understand what I planned to study. She mentioned the theories she subscribed to, indicating she wished to participate in my study rather than merely grant me permission for entering a site. However, it would have been difficult to control my study because it is different from the ethnography which other students did. Consequently, the hijack of the agenda did not happen. My initial failure at gaining data access had resulted in the critical turn in the second application for data access.

Second application for data access: a critical turn: After this first rejection, it was necessary to find some other enthusiastic doctors and nurses amongst other health care workers in other northern provinces, who were willing to grant me access in order to record counselling sessions-a new and untried method and technique in Thailand because I would be using not only an audio tape recording but also a video recording. The second application for data access was successful. The original contribution to my data access came from a friend who was a doctor who had graduated in London. He called his friend in Thailand, the director of a community hospital. He told me to send a statement about the research to Thailand as quickly as possible because the director wanted to know briefly what I planned to do. This time, my research statement was in the hands of a gate keeper who was a member of the medical staff. The director did not pass my research statement on to another. The gate keeper, who was a doctor, read and

scrutinised it himself. Consequently, he had full understanding of what my study was concerned with and how it was useful to his work. He decided to give permission for gaining access. Then, in early December 2002, I returned to Thailand to conduct the field work.

Soon afterwards, I was introduced to other relevant people. The director himself drove me around in order to introduce me to medical staff in his workplace. Then he introduced me to other directors and counsellors. The director's action of introducing me to other medical people meant that I was recognised as someone whom the director trusted. However, this alone did not guarantee I would be able to get to the heart of the field research. I still needed to bear in mind that my data collection would be made possible by good relationships with nurses, patients and their communities.

2.2.2 The value of the research in the area of counselling studies

This study has a myriad of contributions to make in the area of counselling studies. This was significantly underlined by the director whom I contacted. His statement referred to the need for the psychosocial support derived from social research to serve medical research and missions. The director replied formally, on behalf of three other hospitals, describing what medical staff expected from the study, and that the new methodology used within it should be used more widely in the Thai research communities. He was certain that this methodology could be significantly applied to further health care studies. In addition, opportunities to undertake other research in the same area would be offered in the future.

The value of the study has been confirmed by some of the nurses involved in this study. In a formal interview with the chief nurse of one hospital, she expressed the view that she expected me to do other research by means of the same methodology. She suggested that other disease areas, such as thalassemia, gallstone and cancer of the uterus could be studied by this methodology. Whilst collecting data for this study it was clear that these other diseases could be found in close relation to the northern people and their way of life in the province. Most patients in northern areas were diagnosed associated with them. The value of the research in the area was reflected in the willingness of medical staff to participate in my study.

2.2.3 The willingness of doctors and nurses to participate in the research

Good relationships between the director and me developed rapidly. I realised that the director was very research oriented, and has won awards in health research. This might be associated with his interest in my study. In particular, when he learnt that this study would be investigated by means of new methodology, he declared his interest in the methodology in the first formal letter to his response to a request for access by my supervisor. He stated that he expected to further this methodology for use in the Thai research communities, especially in the area of health research. In addition, three other directors who also sponsored me in the same area were pleased to welcome this health communication research to be done in their areas. However, Lindlof and Taylor (2002, p.105) argue for the grant access by pointing out that '[s]imply obtaining permission from a gatekeeper or sponsor does not guarantee a successful entry'. It also depends on the cooperation of many other persons. Consequently, I approached nurses as second gate keepers.

The relationships between me and the nurses in the settings resulted in a great deal of contribution from those nurses. The issues here relate to the work of Mason (2002) Mason (ibid, p. 94) shows that '[d]eveloping relationships in your setting can be very difficult'. It is important to highlight how developing the necessary relationships could be achieved, but it does depend on the personality of the researcher. In addition, I believe that the close ties between the nurses and myself were developed gradually, owing partly to the nature of the people in the area. Generally northern people have been generous, at ease with and sincere to others. This is reflected in the fact of how rapidly I could develop the relationships. Furthermore, Mason also points out that '[r]elationships in research settings are likely to develop and change over time' (ibid, p.95). It is hardly surprising to discover that my relationships with the nurses became closer over time. Most of the nurses who were counsellors were more senior than me. The way in which the counsellors treated me is also covered in the next section. As well as this researcher's personal characteristics, the relationships with the counsellors were constructed through my intention to study AIDS counselling and the fact that the type of study did not burden the counsellor with additional work. This resulted in my gaining trust and huge cooperation from medical staff,

particularly nurses. Nurses and some medical staff showed their willingness to be involved with my study, and declared their interest in my research, based on the following reasons.

First, the general relationship between nurses and their doctors are based on vertical power. Nurses should follow what doctors assign them to do. However, the nurses did not decide to participate in my study due to an order from their directors. They realised the value of the research. While much research on AIDS was concerned with ethnographic study, this study was concerned with something new to them. Counselling was the main theme. When I showed my interest in this kind of job, this situation is highlighted. Thus nurses realised that they were doing a good job, and were pleased to offer me cooperation with data collection.

Second, it seems that nobody wants to do the job of counselling. It can be said that it is a dead end, and counselling is a stressful task. Staff who perform counselling encounter the loss of the patients, are associated with a taboo subject, and there are few people willing to share or discuss their experiences surrounding issues. My presence in the research site was an appropriate time for counsellors, and encouraged them to tell other people and their colleagues that they were doing an important task. They realised that getting involved with my study created value for them.

Third, although this kind of research had been conducted in a western context (for example Peräkylä (1995) conducted research on AIDS counselling) never before has this kind of research topic has been studied, let alone with new methodology, in the Thai context. Few researchers on AIDS and related issues would conduct research on counselling. Most AIDS research surrounds the subject of effective prevention and condom campaigns. While I was gathering data, another quantitative research study of medical staff was concurrently ongoing. Nurses were asked for cooperation helping to administer questionnaires. They had to make an appointment with patients and ask them a lot of questions, then all the answers were filled in on questionnaires. It was difficult for the nurses to collect the data because the answers required by the questionnaires were not the same agenda that patients desired to discuss. Hence, nurses had to expend much effort to get relevant answers. This kind of research was beyond the bounds of their routine work. In this area, the data recorded might be termed unnatural

because nurses had to interrupt their conversation in order to ask patients particular questions. In contrast, in my research conversation and turn taking between nurses and patients were allowed to proceed more naturally.

Fourth, nurses were interested in my study because it was being conducted by a Thai student based abroad. This indicated that the research was of international interest. The research site is a small rural area. It is always forgotten by tourists and people in other areas. The area is still economically backward. The selection of this area as the setting for field research can make this area become more valuable.

Last, this research would study the language used between nurses and patients during a consultation. Thus its methodology should facilitate the analysis of two-way communication. It was necessary to apply the methodology of conversation analysis, which is new to the Thai academic society. This methodology must reveal how two parties have socially interacted and how each can understand the other's turn. Most research undertaken using this methodology has been conducted using audio tape recorders. In contrast, data collection for this research was conducted by video recording. This can be seen as a new paradigm for doing social science research because researchers can have access to both verbal and non-verbal communication during a consultation, something which audio tape recorders could not offer.

These reasons all influenced the willingness of nurses to become involved with my study. The nurses wished me to learn all angles of AIDS care, and this led them to approach patients to become research cases. The nurses' great willingness to help is reflected in the actions they performed.

First, the nurses provided me with access to patients, hospitals and patients' homes. When nurses introduced me amongst their colleagues, they all welcomed me to observe in the hospitals as an insider. They did not have any reservations with respect to my research, thus allowed me access to most sections of the hospitals. The addition of access to patients and patients' homes were also made by nurses. It was clear that the nurses had personally negotiated with patients, and that they were pleased to participate in this research. Here, it cannot be overemphasised that nurses had won the trust of most patients. I could build up relationships with patients through their good relationships with the nurses. I could not talk directly to patients because most patients were reserved. Some still

feared stigmatisation and some still kept their infection confidential. Thus gaining access to patients was only possible through another second gate keeper, the nurse. Most patients felt more secure in terms of confidentiality and their own protection with nurses. Nurses helped identify me to patients and made patients and their communities aware of me. The way in which I was identified by patients was extremely important to my achievement in data collection, and it was clear that I was identified by them as a friend of the nurses. They could notice how I was close to their sole confidantes. Thus, they also relied on me.

It was clear that patients regarded their counsellors as sole confidants. The patients who were approached were middle to lower class, working as labourers and in agriculture. While I was collecting data, it was apparent that most patients were pleased to see their counselling nurses, and sometimes came to see nurses for purposes other than health talk. This important aspect was revealed by one nurse who revealed that the nurses occasionally provided patients with resources, such as luncheon boxes and a little money, such as bus fares, in a subtle way. In addition, some nurses talked with them about their concerns about children, not taking place in the counselling room, but in the building's corridors. I observed these occurrences clearly from my desk.

However, although nurses themselves had approached patients, some declined to become involved with my research, not wishing to be recorded on video although some of these did allow me to record their voice on audio tapes. This clearly shows that these patients were aware of their rights and protection of privacy. One important aspect is that no patients were coerced or forced to cooperate in the research. This will be described more fully in the next chapter.

Second, the nurses provided me with domestic support over the course of the data collection. I was looked after by them both in leisure time and working hours. The nurses took it in turn to drive me around the province, which aided my understanding of the way of life of local people. Occasionally when I required privacy to sit down to revise what I had done recently and write down what I should do the next day, I instead hung around outside with some nurses. I had done this for the nurses' sake. In this area, Goward (1984, p.105) points out this by stating that '[w]hilst the fieldworker may feel the need for privacy, both for work and for his or her emotional well being, it is important that this should not disrupt establishing good relationships'. Thus, the best way to maintain good

relationships was for me to hang out with them.

Third, I informed the nurses that my study would partly be concerned with the theoretical knowledge in which they had been trained. It would aid the research if they could teach me what they learnt about AIDS counselling. Some nurses gave me copies of relevant documents they obtained while participating in counselling courses.

Fourth, another way in which the nurses made data collection possible was simply because they had been counselling patients for a period of time and had their experiences, as data, immediately available to me. They were aware of my major concern that I obtain an adequate number of counselling cases, and they would ask me how many cases I had recorded. This would prompt them to make further attempts at approaching patients for my study. In addition, the nurses helped me by writing down some patients' background and histories.

Fifth, one of the major contributions of the nurses was their help in transcribing their own counselling cases. The nurses understood my difficulties with the language used during most of the consultation cases, and were pleased to provide their help. Some nurses who were too busy asked for someone trustworthy to do it for them. For example, the chief nurse had passed her cases to one of her staff. She was actually an HIV patient who is working in that hospital. She was extremely careful about confidentiality and protection of rights, she had direct experience with what other patients might be concerned about.

Sixth, nurses helped me work through the emotions and stress caused by my undertaking this sensitive research. Emotional disturbance was one of the difficulties which I encountered in the field settings. Conducting this stressful fieldwork with people living with HIV affected me. Although I had prepared myself to undertake this field work, I still felt stressed. It was my first time to reside in a hospital, which was identified by others and myself as a place only for sick people. It was particularly a place where there had been a lot of people dying. Everyday, I would see and talk with patients who needed someone to listen to them, which was the real world situation in which they were involved. In other words, doing this field research aimed to discover the real world of the nurses and patients. Most patients talked about their hard lives with me. Of course, I usually felt sympathy toward them, although I tried hard to be neutral. In this regard, it was difficult, especially when I saw someone who was going to

die because dying and death were not often encountered in everyday life. Thus, it was not easy to be seemingly familiar with them. In addition, it seemed unacceptable when compared to the life of people in the big city, Bangkok, who live in industrial and commercial areas. When I came back to Bangkok, I found the contrast startling to be surrounded by opportunities to access resources economically, socially and educationally. National development has not spread to all of the nation and most patients are so poor that they cannot afford even food. Most patients encounter a lack of opportunity in society as a result of their illness. For example, one young female patient was expected by a counselling nurse to have blood tests and the level of her CD4 count¹² in her blood, but she could not come to the hospital because she could not afford the test. In this area, I as the fieldworker could help her. Helping any patients must be done with caution because it might place one in a dilemma or be contrary to ethical practice.

I considered myself lucky in receiving emotional support from the nurses. Nurses always talked with me about those experiences and paid attention to my worries. They emotionally supported me by talking about the fact of life by applying Buddhism. Whenever they found me stressed and bored, they would suggest something that I could do, for example, they took me to some tourist attractions to relax.

At this stage, I should describe my feelings before entering the research settings to contrast with those that evolved whilst I was in those settings. Before entering the hospitals, I was apprehensive about a potential lack of co-operation from nurses and patients and about finding an adequate number of cases. To my surprise, the opposite was true. I received enormous co-operation from most medical staff. Despite the interest in contributing to this research indicated in my initial contact with the institution, I was at first uncertain as to whether the nurses themselves would participate. The nurses might have been reluctant to get involved with this study or may simply have been required to contribute owing to a directive by an authoritative supervisor. This would have resulted in nurses then making little attempt or making only unenthusiastic attempts to approach

¹² The CD4 is a type of infection-fighting white blood cell. When people are infected with HIV, CD4 cells will be destroyed by the virus. Consequently, the CD4 cell count is used to assess the state of the immune system. A patient with a low count may be at risk of developing opportunistic infections such as tuberculosis, cryptococcal meningitis, pneumocystis carinii pneumonia. 'The normal range for CD4 cell counts is 500 to 1500 per cubic millimetre of blood' (see Oxfam International, 2004).

patients. One common belief of the researcher is that government staff might not be interested in research if there are no personal advantages from it. Given these assumptions, I became frustrated, exhausted and exasperated prior to entering the research settings.

In summary, the nurses decided to participate in this study because they found it useful. This value of a study to its area of research is an important strategy which can be used in other areas of very stressful work.

2.3 Description of the location

Due to the confidentiality and ethics of this research, the name of the province in which data were gathered must remain anonymous throughout. The researcher decided to collect data in the area without specifying its geographical condition. The area is located in the northern part of Thailand. The province currently has a population of not more than 600,000. It is land locked, not frequented by tourists, even Thai people, in spite of several tourist attractions. It is also considered as one of the smaller provinces in Thailand. However, this area is renowned for its naturally geographic landscapes, natural products and the ways of life of the local people. One can see forests, mountains and peaks everywhere in this province, and visitors could see hill tribe people. Also I observed those people walking in the hospitals during the time of recording the cases. The language used in this province is the northern language. It is slightly different from that used in the capital city, there are several words and utterances in this area which would not be used in Bangkok. Most local people speak the local northern language which is a bit faster in comparison to the language used in most other northern provinces. The people are generous, heartfelt and welcoming, which might be a factor in their being so open to the possibility of this sensitive research.

2.3.1 Description of institutional settings

Within the province, there are more than 10 districts, in each of which there is a district hospital serving its local people. One might be referred to the provincial

Hospital if the district hospital is found ill-equipped, for example if special treatment is needed for a patient requiring intensive care.¹³ A major difference between the provincial hospital and other community hospitals is that the provincial hospital has more medical equipment, more staff, more doctors and specialists as well as more patient beds than other hospitals. I have received co-operation from directors of hospitals to cover four hospitals for data collection. However, there was one hospital that did not offer any counselling cases to this research project. As a result, all data on counselling cases and interviewing cases were gathered from three hospitals. The location of the 4 hospitals is divided according to public health area. Geographically they are located approximately between half an hour to forty five minutes by car apart from one another. The director of each normally works co-operatively with their fellow directors and they have a monthly meeting.

One of the hospitals was small with only 30 beds. Despite the size, this hospital provided the researcher with a lot of good experience and knowledge of several medical aspects. The director was my main sponsor and he made provisions for my permanent accommodation and other facilities such as telephone, facsimile, desk top computer, food as well as an office for the duration of the data collection. The director devoted his own office to me during the data collection. The other two hospitals that provided cases for this study had 60 and 430 beds.

By the time the director had driven me to the other hospitals, I had grasped his standpoint in terms of being enthusiastic towards research. I stayed at his hospital and a lot of hospitality was bestowed on me by the medical staff. But I still felt alone because this hospital was so calm, quiet and non-illuminated and surrounded by mountains. The life here was completely different from that in the capital city of Bangkok, where I used to live.

Then I started discussions with nurses, explaining the conceptual framework of the study to them. Rossman and Rallis (2003, p.149) stated that '[a] clearly articulated conceptual framework is essential for entry'. At weekends, I would stay in the provincial area because every Monday there was a day care service for HIV patients. I rented a room located close to the hospital as I

¹³ The provincial hospital has 430 beds. It is also one of the hospitals where the data were collected.

preferred walking to gather data. A nurse had introduced me to a former colleague whose room I could rent.

On Tuesdays and Wednesdays, I would go back to stay at the hospital where my director friend worked to wait for the cases. The recruitment of cases was quite unpredictable because there were not many HIV patients. Whilst there, I could also conduct observational research on the inpatient's ward. On Thursdays, I went up to record cases at the hospital with 60 beds, which was on the way back to the provincial area. However, my routine over the period of data collection was flexible, as it depended on where the nurses could approach patients to be cases for me.

2.4 Main participants

Nine female counsellors carrying out AIDS counselling were involved in this study. Most of the counsellors were professional nurses, one was a social psychologist, one was trained in midwifery and one was a public health educator. All were trained in AIDS counselling organised by the Ministry of Public Health. They had participated in, at least, basic training courses differing in terms of course title, length of course and venues of training. The average educational level of the counsellors was at least undergraduate level, and some had a postgraduate qualification. Throughout this study, I will refer to all these counsellors as 'nurses' in accordance with the convention in Thai public health settings.

The other participants involved with this research were 53 HIV patients who came to see health care professionals for consultation.¹⁴ Within this study, I will categorise patients into two groups.

The first group came for consultation as newcomers; most had just been informed about their blood test results by medical staff. This does not necessarily mean that they had only recently become infected with the virus. It was not possible for nurses to approach them as potential research cases because they were extremely stressed, mournful and depressed. Thus, nurses would normally

¹⁴ See Appendix B.

approach patients only after a second consultation. Specifically, nurses would negotiate with patients during their third meeting.

The second group was long-standing patients who came for repeat consultations, and most agreed to be recorded on video. It was not too difficult to approach this second group because most patients enjoyed close relationships with the nurses, whom they relied on as their sole confidante. I should explain more why access to patients is not that difficult for nurses. Most counselling nurses were born locally and they preferred to work for their regions. The fact was that they lived in the same cultural community as the patients, and they spoke the same language. Thus, both nurses and patients were in the same context and they had interacted socially. Cultural difference should not be considered amongst the difficulties of approaching patients.

In summary, I did the data collection in three governmental hospitals in one of the northern provinces in Thailand. Nine counsellors, including professional nurses, a midwife, a psychologist, a health educator, and 53 patients gave their informed consent to get involved with my study.

2.5 The researcher's characteristic and impact on field work

I always bore in mind that my own characteristics influenced the data collection. Residing in the research site brought me into contact with different people. The way in which other people identified me depended on my presence and perceived social status. In this section, I show how the social status conferred by my being the director's friend, a university lecturer and a student and my gender, have impacted on the field work.

2.5.1 Social status

Social status is important as it determined how people in the research site interpreted me. The way in which those people regarded me contributed to my gaining access for data collection. I entered the research site with three statuses that of a friend of the director, a university lecturer and a Thai student returning

from abroad.

Director's friend

My status as the director's friend was clearly seen when nurses helped me identify myself with patients, and it seemed to me that patients were pleased to make my acquaintance. However, some of them might take it for granted. One might argue that I could encounter unwilling cooperation from some patients if I was identified as a director's friend, which may be true to some extent. However, in the sites, the nurses repeatedly told their patients that their participation in my study was completely under their own control and would not affect access to any treatments in the future. At this point, I should elaborate that the character of the director who supported me was well-recognised as an NGO doctor. He was well-liked by most medical staff. This resulted in ease of data collection and co-operation from counsellors.

A university lecturer

Being a teacher in Thailand is associated with high respect from others, especially people in rural areas. Teachers are regarded as having higher social status; in their communities, as a university teacher, I commanded respect from patients. Teachers, in the Thai context, are always interpreted as contributors and as second parents to students. Patients called me '*ajarn*', which is literally interpreted as a lecturer. In addition, my personality influenced my access to participants. Several times, the nurses expressed the opinion that I had a warm personality as a lecturer. Most patients felt at ease talking with me. I was a tolerant listener with patients that needed someone to listen to them. This is an important personality trait which fieldworkers must make use of in any settings.

A Thai student abroad

Most counsellors were more senior than me, and this affected the way they treated me. They also treated me as a new learner and a son. They realised that I was a Thai student who was studying abroad. Thus they wished me to learn

holistic care for AIDS patients. This not only affected my recording of consultations, but also other informal activities I was involved with in the research settings. Being a student abroad is fashionably called '*nak rien nork*'¹⁵, and this can be highlighted in a rural area. Some patients were interested in what I was studying abroad, and wished to know what western countries looked like. This helps me continue interaction with some patients. The nurses focused on what foreign teachers, or the so called '*ajan farang*'¹⁶, were interested in. They made attempts to provide my supervisors and readers with interesting tales or eccentricities of Thailand that differ from those in western cultures.

Gender

One major concern of fieldworkers is gender and power. Fieldworkers should pay attention to gender, which may influence relations with research participants. In this area, Silverman (2001, p.59) points out the relationships of gender between fieldworkers and research participants.

'Finding an identity in the field may not, of course, just be about your professional affiliation. Your gender in relation to the gender of the people you are studying may turn out to be very important in relation to how you are defined and, therefore, what you find out' (Silverman, 2001, p.59).

It can be said that the gender issue is complicated and might impact on my data collection because I had both male and female patients in my study and female counsellors. Thus I was always aware of my gender. However, my gender presence was also useful sometimes. I made use of the gender presence when I had to gain access to facilities through doctors. Sometimes, I was told to help in particular counselling sessions because I was a male.¹⁷ My gender was not a problem amongst doctors because they were male. My gender seems to be less of

¹⁵ The term '*nak rien nork*' denotes a Thai student who studies or graduates from abroad. Nattama Pongpairoj Thai linguist at the Department of English, the Faculty of Arts, Chulalongkorn University, helped me spell this word and some others in the next footnotes.

¹⁶ The term '*ajan farang*' refers to my supervisors. The word '*ajan*' means lecturer and '*farang*' denotes western people from off shore countries who have blond hair and blue eyes.

¹⁷ While one nurse was talking to a patient who was a monk, I was asked to serve the patient beverages. This job should not be done by a female.

a problem with nurses because most nurses were senior to me. The way in which they treated me influenced my gender presence. However, at first, I noticed that some patients had some concerns about my presence because I was a male researcher, and accordingly some patients were reluctant to talk with me. Several times I was required to record consultations between female patients and nurses and to interview some female patients. I felt that there was some embarrassment. Nevertheless, soon after they had been informed about me by the nurses they understood what other social statuses I held. It became increasingly influential on my ability to collect data. In my own opinion, the relationship between my gender and my presence in the research sites affected the status of the observations to some extent. The way nurses introduced me in the site also affected the way in which patients interpreted me. Importantly, other characteristics I was identified with influenced my gender presence in the site.

In summary, we have seen that the involvement of nurses resulted in my gaining access. Four characteristics heavily influenced the field work, and made data collection possible. In addition, the willingness shown by nurses led to the achievement of the many activities which played a major part in making this study clear, more complete and possible. However, one aspect must be underlined here: whatever influence these characteristics had on data access, collection and analysis, they did not have any impact on the quality or the nature of the data I obtained from counselling sessions. This is because the data recorded was naturally occurring talk, although there was a separate gender aspect in that interaction.¹⁸

2.6 The activities of the researcher

I planned most of the formal activities I participated in, such as the training courses, and learning about AIDS in the contexts of a hospital and counselling. Sometimes, though, I would undertake activities spontaneously I will illustrate the formal activities and then follow with the informal activities. The description

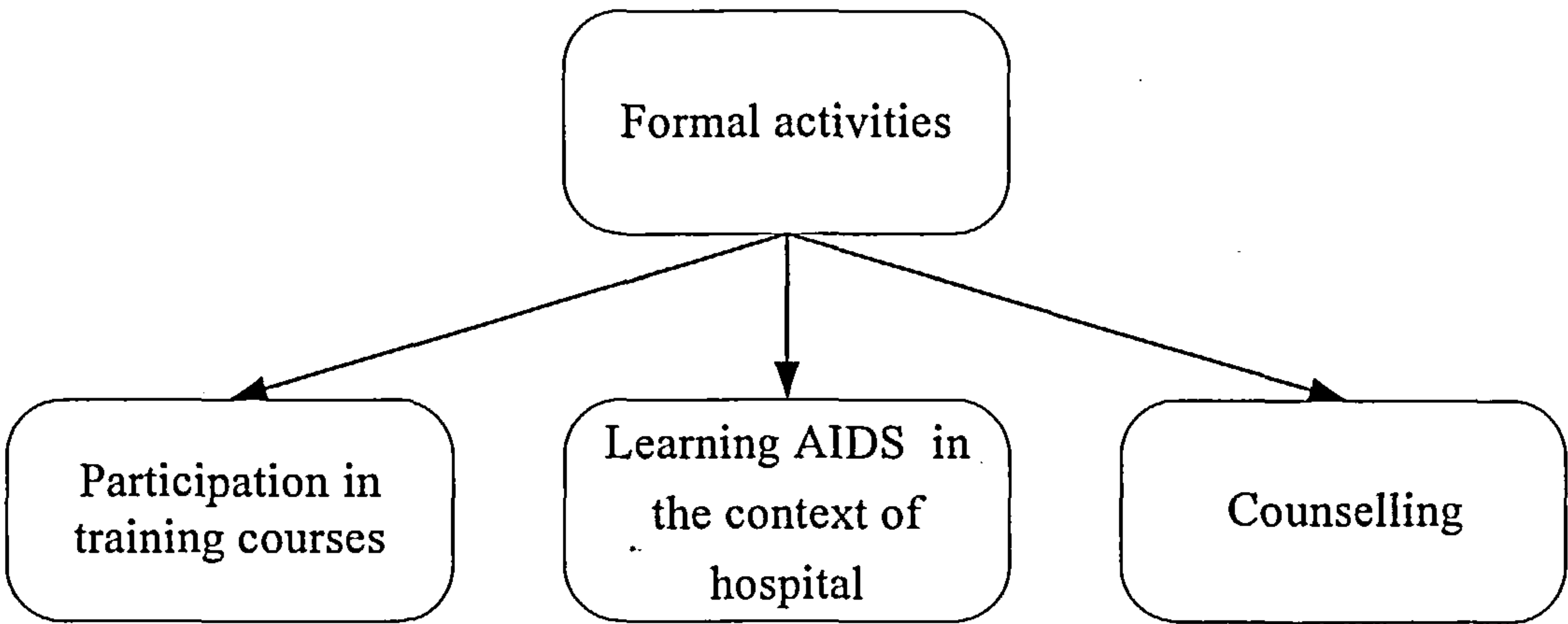
¹⁸ Some nurses touched and stroked patients. This was a gender issue in interaction. My gender presence was not involved with such interactions. Consequently, my gender had no impact on data analysis. However, it might impact on the analysis of ethnographic data.

of most of the activities I conducted or participated in will be kept brief. Those that are important will be shown in more detail.

2.6.1 Formal activities

I prepared myself for the fieldwork by attending counselling sessions and understanding AIDS in the context of hospitals. I expected to participate in these activities formally. Data and information from these formal involvements contributed to the completeness of my study. I show these formal activities in diagram1.

Diagram 1. Formal activities



Participation in counselling training sessions: I wished to participate in counselling training courses because I wished to learn what angles were important, and what I should be aware of when I entered the field site. I participated in two courses in relation to counselling. The first training course was organised by an office under the administration of the Thai Ministry of Public Health. This office is in the Nakhon Sawan province, which is in the south of the northern part of Thailand. At this point, it is useful to illustrate how my participation in counselling training came about. Soon after my arrival, I asked the nurses for information relating to training courses on AIDS counselling. In January, a formal letter was sent to the director inviting professional health care

staff to participate on such a course and I was informed of this by one of the counselling nurses. I contacted the organiser of the course and was subsequently invited to take part. The only thing required prior to participation was a formal letter signed by the director of the first hospital nominating me as the researcher in the area. This 4 day course was held in the first week of February 2003 in one of the northern provinces. There were 40 participants on the course who were working in the area of counselling. Most of the participants were professional nurses, some were public health staff, and a few were staff from the Department of Behaviour Control. Some of the participants had dealt with HIV patients, some were doing counselling with drug users, and some of them were looking after prisoners. The aim of this course was to teach the participants to be counselling trainers. I participated in this training course as an observer. During the 4 day training course, some events were recorded on video, and all sessions were recorded on audio tape.

I had received information on another AIDS counselling training course from a friend who was working at one of the non-governmental AIDS organisations in Bangkok. She had recommended that I contact one of her friends working at another AIDS organisation. I then sent a formal letter with a letter from my supervisor attached, to the director of the organisation. After one week, one of the organisers called me to participate in the training course, which was held at a hotel in Bangkok. This course was designed for volunteers who applied for a hotline counselling position in the organisation. At the end of the training, participants would be assessed as to whether they were suitable to be a counsellor or not. This course began in early March and involved a visit to the organisation. All volunteers were taken to observe equipment and resources in the office such as telephones, facsimiles, tape recorders, video recorders and reference books. I missed this visit because I was informed that it was not necessary for me to attend. Nevertheless, I was invited to go to the office at any time available.

Most counsellors will have been trained, at least, on a basic counselling course, and it was on this basis that most of the contents of the courses I attended were designed. Some nurses would then personally seek out more advanced courses, which could more specifically address their needs and interests.

AIDS in the contexts of a hospital: I applied ethnographic methods in observing how AIDS care was conducted in a hospital context. Patients were

treated in hospitals, but as part of a home care package they were also followed up at home. Patients were treated with antiretroviral (ARV) drug therapy. Nurses followed up on this treatment and visited patients at home. The taking of ARVs may put patients at risk of allergic reaction. In addition, the involvement of a third party in health care is important. Where patients had revealed their infection to their relatives, the nurse could follow up on treatment by inviting the patient's relatives to discuss health care and the patient's progress. The HIV patient group network plays a role as a particular setting for patients to exchange views, knowledge and experience. Patients are encouraged to participate in the HIV patient group network so that they have someone who is in the same circumstances to listen to them. In addition, they can act as a source of information for each other. Some may have information on careers and employment. The patient is encouraged to participate in this network for emotional management. However, before the nurse proposes that a patient join this forum, she will assess how ready the patient is to disclose their infection to other people

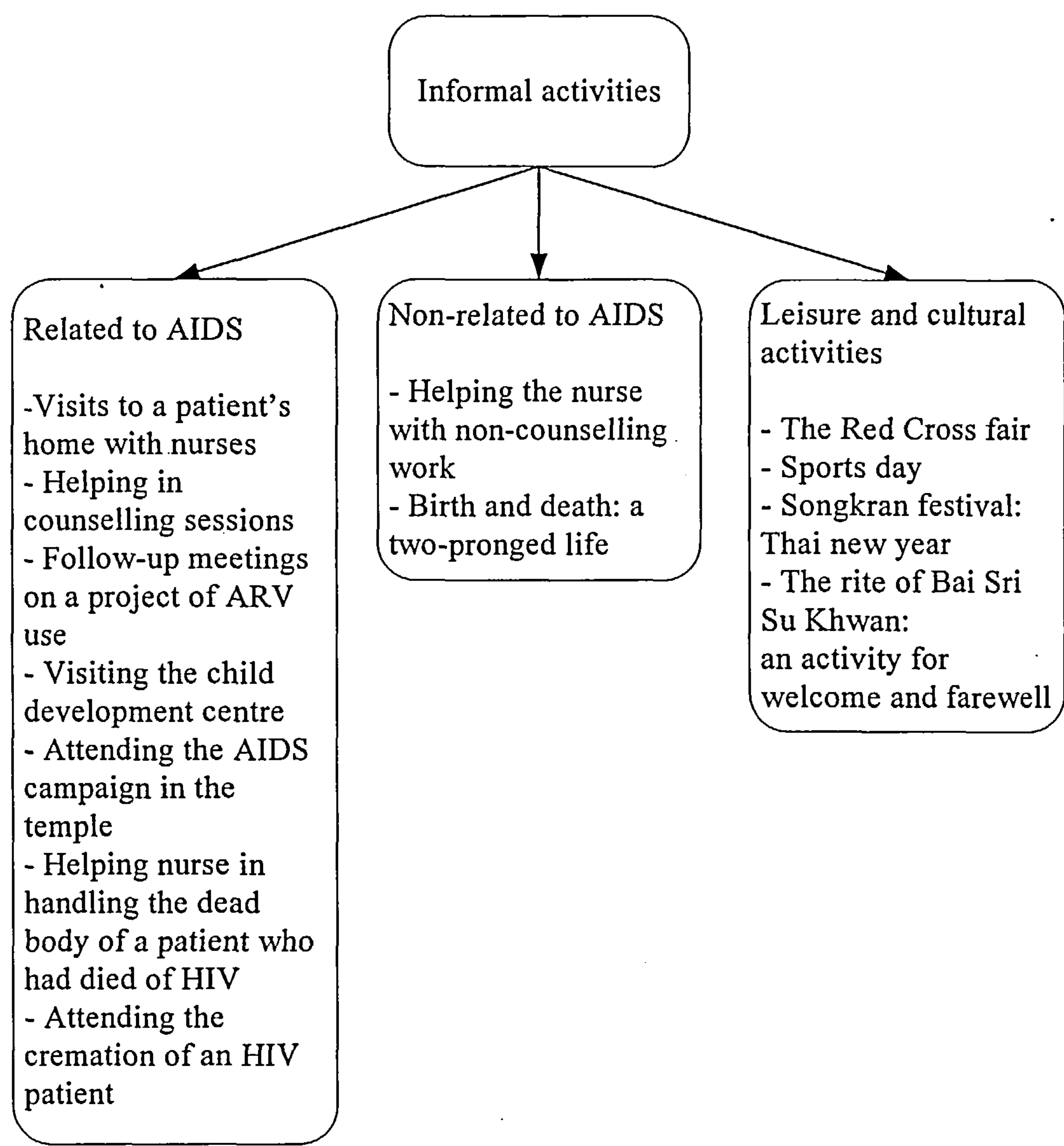
Counselling: I wished to know what the counselling looked like.¹⁹ More precisely, I wanted to concentrate on what happened during a counselling session. Consequently, my ultimate aim was to record counselling sessions. I expected to gather counselling cases as soon as possible. Instead, I had to wait some time before I collected the first case as it took rather more time than expected for nurses to approach potential cases.

2.6.2 Informal activities

As well formal activities, I participated in other informal activities. This was possible because of my relationship with the nurses. Some of these informal activities were not directly related to the job of counselling, but they were not entirely unconnected. Consequently, the counsellors wished me to learn about them and see what they were like in the villages. I categorise informal activities into three groups: those related to AIDS, those not related to AIDS, and leisure and cultural activities, as shown in diagram 2.

¹⁹ In Chapter Four I show counselling in practice. This chapter illustrates in more detail what the counselling looked like and how it was conducted.

Diagram 2. Informal activities



Informal activities related to AIDS

Visits to a patient's home with nurses: Visiting a patient's home is seen as one of the nurses' duties and is one way to follow-up treatment. I had an opportunity to visit patients' homes with nurses, which had been initiated by nurses. This indicated that the nurses wished me to increase my understanding of the way of life of the patients. The nurses believed that in a sense the infection would be more easily understandable if I visited the patients at home. Prior to any visits, the nurses would ask for permission from the patient and their relatives. This was

because, in the past, discrimination toward a patient had emerged following a nurse's visit. Some patients were not open to others, especially their neighbours. When others had seen the hospital cars or vans, they would suspect that there was an acute patient. Some neighbourhoods had already suspected something. A visit from nurses and a van or car belonging to the hospital parked outside the patient's home could confirm their suspicions.

It is extremely important to visit AIDS patients at their home because some patients might improperly take medicines and consequently, nurses have to keep an eye on them. Another factor is that the nurses can be kept informed of patients' physical and mental progress by their relatives, such as their husband, wife or parents. In addition, visiting patients' homes informs nurses about their economic status, relationships in their families and the educational dimension of their children including their status in society. To give an example, one day, a nurse and I had visited a patient who had been infected with HIV by her husband several years ago before. At the time of the visit she had to take ARVs as part of her daily life. She was not at home on the day we visited but the nurse was able to find out about her medical history from her mother. An important aspect in relation to people living with AIDS was that she was discriminated against by her neighbours.

Another time, two nurses and I went to visit a female patient. She too had been infected by her husband, who died several years ago before. She did not tell others, even her new husband that her first husband had died due to AIDS. She would instead refer to cancer as the main cause of her first husband's death. At the time of the visit she was staying with her new husband and one child. On the day we visited them, they had been fighting, and she had gone to stay with her mother in the same village. It seemed during this period of time that the nurses' jobs encompassed a wide range of responsibilities. They worked to divide those responsibilities between them by discussing what they should do, and then separating to perform their allotted duty. One went to the home of the mother of the female patient, and the other one stayed with the husband. Both nurses had made an appointment with them to see them at a place of counselling. Interestingly, several aspects of living with AIDS were illustrated in the recorded video. Visiting patients' homes has enhanced my understanding of the realities of nursing people living with AIDS in the Thai context. AIDS counselling in the

Thai context should be shaped by this activity.

The nurses helped clarify the matter of addressing the issue of dread. One experience in particular related to death and dying is at the forefront of my mind. It represents an important illustration of what life is like when death is imminent. I can recall some of it as if it happened yesterday. At the beginning of the period of data collection, a nurse and her husband persuaded me to visit a female patient who was staying near the hospital. On the way to her home, the sunset had just begun so it was pretty dark. The patient's village was surrounded by dense trees however, we could still see the road. Sometimes, the car bumped due to the rough roads. When we arrived at her home, there were two motorcycles parked outside her home's fences. We looked into her home, which was a two storey house. There was nothing much downstairs. In the car, the nurse had implied that she thought something serious was happening because she had observed the two parked motorcycles. We walked into the patient's home and met her father sitting at the foot of the stairs. He invited us to go up. We had been told by him that she was really ill. We met a monk sitting outside the room. He invited us to see her. In my point of view, she was living death. She was in a coma surrounded by her relatives. There was a great deal of sticky sputum regularly coming out of her mouth. I heard her voice like someone snoring. The nurse told me to sit beside her. She introduced me to her mother who was sitting at the feet of her daughter. Her mother had a small handkerchief on her left shoulder while she was crying. There is no need to describe more in terms of my emotion and stress. However, as a researcher, I felt the best thing to do was to keep silent. I can recall some of what was spoken by the nurse, but my memory does not extend to the details of speech or body movements. The nurse told the patient's mother that if the patient could survive the night, she would live longer, but if she did not survive the night, the patient's mother would have to accept it. My memory of these events was aided by my field note book, in which I recorded data daily, as soon as I got back in the car after the visit. After seeing the patient we came out of her room and talked a little more about her illness. The nurse then changed the topic and they discussed more about what I was doing in the area. At this time, we learned that the monk sitting outside was the patient's younger brother. It is useful to explain further that according to Thai belief, when one is dying, if it is possible,

one will be told to think of images of the Buddha until one's last breath.²⁰

Helping in counselling sessions: Most nurses would carry out their counselling work at their hospitals, with the exception of the nurses from one hospital. I would help them carry medical equipment to the car and we would then travel to the counselling place together. There, I would help them arrange all the equipment on the table. This equipment would be used for blood tests and checking the blood pressure of patients. Sometimes, I would inform nurses about the patient's arrival. In this area, I recalled that keeping some patients waiting was not appropriate. A patient's health may be jeopardised if they become depressed. Some nurses believed that some patients might decide to do something drastic or even unexpected such as attempt suicide, if they were kept waiting too long.

Follow-up meeting on a project of antiretroviral drug use: I had an opportunity to participate in a follow-up meeting. This half day meeting was organised by the provincial hospital. AIDS counsellors and other relevant medical staff such as doctors, pharmacists and nurses from all the hospitals in the province were bound to attend so as to report their progress and some substantive results following the launch of a project on an antiretroviral drug use. In the first half of the meeting, a short report was presented from every hospital. For the rest of the session, those attending were divided into three big groups according to their job descriptions. Each group was assigned to discuss some constraints arising in their routine work. I had permission from medical staff to record the meeting on video. Some important aspects of the counselling job were underlined in the meeting. There was clear evidence that most counsellors had excessive workloads. They also experienced problems of stress and emotional disturbance. There was felt to be insufficient support in terms of resources from their hospitals, and as a result, they could not complete their duties effectively.

Visiting the child development centre: I had not thought before

²⁰ The patient passed away three hours after we left, and we participated in her cremation three days later. One piece of evidence that should be presented here in relation to how deeply I had become involved with the research data is a letter written by the dead girl. She had written a letter a year before her death. Her letter was read during her cremation. The word 'AIDS' as a cause of her death was omitted. Interestingly, this letter seemed to be her testimony. The young monk gave me the original letter from which to make a copy.

commencing with the field work how a visit to the child development centre might be necessary. One day when I was not recording the data, the nurse and a leader of the HIV network in the area invited me to visit the child development centre. In my opinion this was not a routine visit, and I will refer to 'counselling with the teachers'. The nurse and the leader attempted to convince the parents of other children and the teachers to give permission for one particular child to attend the centre. The nurse had tried to educate them about AIDS, in particular how people became infected with HIV. Unfortunately, most of the parents and some teachers were unwilling to allow this child to learn in the centre because his father was an HIV patient.

Attending the AIDS campaign in the temple: One activity which could be seen as one of the duties of the nurses was involvement with a campaign on HIV/AIDS. One nurse at the provincial hospital, who was an expert speaker for the AIDS campaign in the area, had invited me to observe the procedures of the campaign in one temple. Volunteers from several districts around the province attended the campaign. The nurse informed them about AIDS again, although they had heard about it before. They then exchanged their views about effective prevention, including how they lived with people living with AIDS.

Helping nurses in handling the dead body of a patient who had died of HIV: One day in April, I went back to stay overnight at the first hospital as there were some cases that could be recorded the next morning. My routine was not different from that on some other days. After dinner, I walked down to a patients' ward. Some nurses had begun an ordinary conversation and talked about the hot weather, and my feelings. Then I was told by one of the nurses that a girl with HIV was being admitted to bed number 32. The bed to which she was admitted was in the corner opposite an isolation room and was reserved for intensive patients, such as HIV patients or cancer patients. One of the nurses added that the patient could provide a case for my study. She was 32 years old and came from Chiang Mai. Chiang Mai is a big province and a major tourist attraction amongst foreign tourists, located far from where she was admitted. At first, I did not understand as to why she was being admitted here. The nurse said she would help by informing the counselling nurses to approach the patient in the morning. Unexpectedly, the patient passed away ten minutes later. One of the nurses had gone to her bed and scrupulously checked her heart beat, and then

walked back to the other nurses and me and said that the patient was already dead. It was approximately 11.45 p.m. It would not have been surprising had she been in a coma. By contrast, at the beginning of our conversation, some nurses said that she was not in a coma and her death was not considered imminent. She had looked quiet and sad, as if she was worried about something. It seemed to another nurse that she had told nobody about her infection, even her husband. This clearly meant that everybody who stood by her bedside until she had taken her last breath did not know her medical history. At this stage, I discovered an important answer as to why she had to be admitted there; she was afraid that someone else would learn about her infection. This was revealed by nurses thereafter. One important aspect is that telling the truth to her husband and relatives can be a two-edged sword. She might have been discriminated against if her relatives denied her illness. By contrast though, her death would not have taken place in an institutional setting. She could have died at home, surrounded by her relatives, if her relatives could accept her illness.

Here, I describe my own direct experience of the process of handling a dead body. One nurse told me to dress the way they did: I had to wear a long green medical gown, double rubber hand gloves and a medical mask. We walked to the patient's bed where one nurse had concealed the area with curtains. We then started the procedure of wrapping the body without any doctors. Here, it is important to remark on one aspect on death in an institutional setting. Sudnow (1967, p.43) states that '[t]he higher one's position as a nurse or doctor in the nursing and medical hierarchies, the less likely one is directly to witness exposed dead bodies, and the still less likely is one apt physically to handle corpses'. This still appears true because only nurses handled the dead bodies, and this appeared to be part of their routine work. The work on AIDS and related issues would normally be done by nurses.

Attending the cremation of an HIV patient: The female patient had been in a coma while a nurse, her husband and I had visited her. The nurse called me in the next morning to tell me the news and invited me to take part in the cremation, to take place in three days time. During this time her relatives had arranged the Buddhist ritual at home. Her cremation was held at a cemetery near her home.

Informal activities non-related to AIDS

Helping nurses with some of their non-counselling work: When there were no any consultations to be recorded, I used this spare time fruitfully. Thus, I helped nurses carry out their non-counselling work and thereby acquired an overview of their work while they were nursing patients. When I had to stay on the patients' ward, I helped nurses discharge some patients. I helped nurses bring patients to their beds, and sometimes, I would answer some general questions: for example where patients' relatives had to pay treatment fees. In addition, some patients' relatives had thought that I was a member of the medical staff and asked where they could get new pyjamas and bed sheets. Several times, I helped update when it was time to change a bottle of blood or intravenous tubes for some patients. I helped nurses carry intravenous sets to a patient's bed. In the case of acute patients, the nurses would help identify me to the patient and their relatives. I also cleaned medical equipment and I cleaned and wrapped a corpse.

Birth and death: a two-pronged life: Although this study has examined the language used during a consultation between nurses and HIV patients who might be considered as imminently dying ones, a part of it has addressed some important aspects of birth. One great, and unexpected experience, was the opportunity I was given to observe, stage by stage, the process of bringing new life to this world and the process of dying and coping with a dead body. This opportunity was granted by the director. In this regard, in my opinion, an observation in the research site is one of the best ways to increase my understanding about social phenomena. It was a crucial factor in helping me grasp the relationship between theoretical knowledge and real practices in one setting.

With respect to the process of birth, I was offered the opportunity to observe a caesarean section, which I did not understand at first, and then she explained more what this word meant. I showed my interest and I asked for permission from a doctor. It would be wrong to assume that a female patient would be pleased to have me observe her operation so the nurse asked for her permission. Again, I was undoubtedly welcome. One problem that emerged prior to the operation was that I did not know how to wear the medical gown and hat in the way required for medical staff in an operating room. As a result, one of the

nurses helped in dressing me. This was the first time I had observed a caesarean section, and it was also the first time I had seen a doctor and nurses working cooperatively working in a team. I found it scary when the operating knife cut into the human body. It was fantastic to see inside a human body, and more fantastic still to see a doctor extracting a baby. As noted earlier, observations in the study setting could help me grasp the relationship between theory and practice. It is true that birth will bring a new arrival. Medical staff tried hard to keep the baby breathing. The purpose of the nurse who wanted me to observe this process was that she hoped to allow me to compare the process of birth to the process of dying, and handling a dead body. It was a positive experience. Most importantly and interestingly, I experienced both the death and birth of people in institutional settings.

Leisure and cultural activities

The Red Cross fair: The director asked me to attend the Red Cross Fair. This was because I could learn about some close ties between the communities and the hospitals. During the fair, medical staff of the hospital would offer free health tests. Several people who were at risk of any disease could have the test. If someone was seen or considered in relation to some diseases, medical staff would recommend them to go to hospital. This could imply that it was not only the annual fair, but it was also one way to tackle the malady crisis.

Sports day: This sports day is organised annually and all hospitals take turns to host it. Although a sports day was not directly related to my research, it further assisted in my good relations and cooperative work amongst the three hospitals. In addition, participation in this day can allow the researcher to become closer to medical staff.

Songkran festival: Thai new year: Thai people annually celebrate this *Songkran* festival nationwide in April as Thai New Year. Geographically, Thailand is located in a tropical zone. April is considered as the hottest month. This may be related to the use of water during *Songkran* festival. Thai people celebrate this festival with water, and most people who move around outside their home will get soaking wet. They will soak each other. This occasion brought me to meet one senior doctor, who used to be the director of the provincial hospital

during this period of time. Indeed, this was not the first time I had met him. I was introduced to him by the former member of medical staff who was my landlord. He used to work as a chief administrator of the provincial hospital, but had retired early and become an owner of accommodation. Whenever I had to stay in the provincial area for counselling cases, I would stay at this accommodation. At the first meeting, this retired doctor had confirmed that my social research was interesting and that he could grasp its contribution. This doctor was important to me because in the past, he used to be the director of the provincial hospital and the leading doctor in this province and had played an important role in some political crises. He had roots in good medical traditions of treatment. He always coaches new doctors and medical staff in the proper treatment of patients.

The rite of Bai Sri Su Khwan: an activity for welcome and farewell matters: I took part in *Bai Sri Su Khwan* in the research settings. Before discussion on why this activity is important in this research, its origin should be illustrated although the origin of this rite is somewhat unclear. Thai people believe that *Khwan*, which is intangible would be with alive people. Then, we sometimes need to call *Khwan* back when it has gone away. This rite is believed to bring prosperity, auspiciousness and happiness to one.²¹ Whenever one is going to be away from home or come home, this rite should be arranged in the local region.

For the first involvement, I was invited by a nurse to take part in this rite of *Bai Sri Su Khwan* organised for her daughter. Her daughter was going away from home for a new life at university: she had just been granted a place at one of the famous government universities. Another aspect of this activity that should be emphasised is the participation with patients.

In summary I participated in a wide range of activities. These were a reflection of the involvement, co-operation and trust given by the nurses. It seemed that the ethnographic data in my study was overwhelming. However, one crucial point is that what I had seen, learnt, conducted and experienced did not affect at all the way in which I recorded interactions. Those benefits from

²¹ Burnard and Naiyapatana (2004) showed that *khwan* (ขวัญ) is the 'life spirit' that is sometimes thought to enter the body through the top of the head, during birth. In addition, they pointed out when people return to their villages, after a long journey, a *khwan* ceremony will be performed by an elderly, female member of the community.

ethnographic study did not affect the analysing of data in interaction, which was done on a natural base. I analysed the data on talk-in-interaction as the talk indicated in each turn.

2.7 Leaving the site

Leaving the site is as important as entering the field site because a researcher should not leave the research settings without expressing gratitude towards the gate-keeper and the participants who have been studied. Of course, when one researcher has to leave the sites, he or she could possibly leave something behind which might be crucial to the research in the long run. Thus, he or she must leave the research site carefully. How I left the research sites depended on what I had obtained and whom I met. My feeling was positive in doing the field research because most medical staff had offered their cooperation. They had tried to provide a large number of research cases and facilities over the period of data collection. In addition, they engendered trust in most HIV patients towards the researcher. In terms of the patients, they were broad-minded and open to being studied. Thus, my gratitude must also go to them.

In addition, although I as a researcher left the site, it did not mean that I would not return again to the province and places where my research data were collected. Most nurses were expecting me to return to the field site either for academic reasons or for recreation. They stated that more cases could be provided if they were required. This was referred to during in depth interviews with most nurses. It cannot be overstated that the directors of some of the hospitals also offered their help in terms of further cases after my data collection had been formally terminated because they expected to see my research complete. Of course, according to the traditions of doing any research, the researcher was expected to provide both negative and positive feedback from the research's findings. Hence, the directors have been waiting for my research's results.

In Thailand when people leave and come home, the ritual *Bai Sri Su Khwan* is performed. As shown earlier, I participated in this ritual organised for the nurse's daughter. Before I left the site, a farewell matter was organised for me

without informing me in advance. This reflected the impression given by patients and I felt gratitude. In May, nurses had helped me set up a focus group session. They informed patients one week in advance. It was a great effort on their part because it encompassed 15 patients from the third hospital and a few from the provincial hospital. When the focus group was finished, I made an informal intimate speech in which I expressed my gratitude for the warm hospitality and appreciation received from all patients. I also expressed a wish to meet them again after the end of my course abroad. I thanked them for all they had done. I then asked for any questions that patients might have. Before departing, one of the patients also expressed his beautiful words on behalf of all the patients. They felt that I was not an outsider, simply because they could talk with me. This time, I could confirm that I had won in achieving their complete trust. In my point of view, this did not, of course, mean that I was a nice guy in the eyes of all patients in the setting. This is because some patients expected assistance from me in terms of scholarships for their children. In respect of this demand, actually I could have provided them with a tiny amount of money, but this was seriously prohibited by the nurses. However, giving them some money could be seen as a two-edged sword. It is useful here to make it clear that one might suspect that some patients seemed unfocussed and this small amount of money could make them lazy. In contrast to this negative thought, their children could have new books and new school uniforms for the forthcoming term. It was confirmed by the nurses that keeping the money in my pocket was better. This can be seen in relation to the premise of one anthropologist. Akeroyd (1984, p.139) points out that '[i]n some field contexts, too, differences in income and resources between the researcher and hosts may be an additional cause for embarrassment, strain and difficulties'. Nevertheless, there have been some indications that spending a small amount of money is sometimes necessary in the research sites.

Looking back to the scene of the rite, eventually the patients' representative stated that they had deliberately prepared something for the researcher. I had no idea what they had prepared. This is the rite which was prepared for me; they took it in turns to tie me with sacred white ropes and took turns to pour scented water onto my two hands. I was astonished, it was truly fantastic and immediately became heartfelt. The husband of the nurse and her son were there. We all took photos together and the nurse gave me a gift. A major

idea emerging from participating in this activity is that this activity organised by patients represents the huge cooperation of the nurses and a great deal of cordial co-operation from most patients.

Before I left the field site permanently, we exchanged tokens, and then all the counselling nurses and some of the medical staff and the director were invited to participate in a dinner which was hosted by myself. We had dinner together in the provincial area. This time I had an opportunity to converse with a doctor, who was the husband of one of the counselling nurses. He stated that doing the counselling was a stressful job for most nurses. In addition, he added that this research was unique and completely different from other social research on AIDS and related issues. He realised its contribution and carrying out this kind of research seemed to be challenging. Virtually all of the medical staff concluded that my research's data collection for my research had been promisingly achieved. Before our dinner finished, we took photos together as a good souvenir.

2.8 Conclusion

In this chapter, I have described how the researcher entered into the research fully supported by the director, who acted as a gatekeeper and who was interested in this study. As a result, he let me into the area to carefully establish relationships with medical staff, particularly nurses. These relationships could be considered as a crucial factor underpinning the observational research. Owing to huge cooperation from nurses, a large number of consultation cases have been recorded. In addition, one important aspect drawn from these relationships is that the way in which medical staff have socially interacted with their patients could be observed at all times, and this provides important insight in the data collection. The nurses have enabled the researcher to significantly take part in other formal and informal relevant activities. A great deal of the cooperation shared with the nurses has enhanced the researcher's deeper understanding of the social phenomena on AIDS counselling. It has led me to grasp that nurses' counselling jobs encompass a wide range of responsibilities. Some activities were completely new to the researcher, such as the process of bringing new life to this world and

how medical staff handled the dead body of someone who has died of HIV.

Although my study was overwhelmed by ethnographic data, they did not affect the natural data in interaction between nurses and patients. In particular, they did not influence the stage of analysing data because we have to analyse talk as it is indicated in each turn.

In the next chapter, I will explore the process of data collection in further detail. Technicalities of data access and how the data were collected are demonstrated. Specifically, audio and video data collection methods and how a process of confidentiality is applied will be explained. In the next chapter, I illustrate the methodology applied to this study.

Chapter Three

Data Collection and Methodology

3.1 Introduction

This chapter is divided into two sections. The section on data collection shows the careful attention paid to ethics throughout the recruitment of research participants. The four main modes of data collection are also shown in this section. The reliability and validity of the field data is illustrated. The section on methodology shows ethnographic methods were used, but the study was also influenced by conversation analysis. The nature of the main mode for recording talk between a nurse and patient allowed me to apply the naturalistic methodology to uncover the ways in which people interact.

3.2 Doing research on sensitive topics and ethics in qualitative research

This study covers what is considered to be a sensitive area because I have to deal with people's lives and their confidentiality. It is therefore impossible to ignore the process by which participants were made secure about their confidentiality and the protection of their rights. It was imperative that I addressed these concerns with them from the outset. Consequently, a proposed agreement on the protection of confidentiality, and a consent form for medical staff and patients were sent to the director of the hospital for his perusal. Small (1993, p.50) stresses the relationship between confidentiality and AIDS by stating:

'Talking about social research and AIDS means concerning oneself with sensitive personal issues. Illness, death, loss, sexuality, sex and stigma are likely to figure large. A concentration on such concerns requires the researcher to reflect on his or her motivation and methodology' (Small, 1993, p.50).

In Small's view, it is particularly crucial that the researcher scrutinises the procedure on confidentiality and the protection of rights within such research. Psathas (1995, p.45) stresses the importance of the protection of rights by stating that:

'Recordings, whether audio or video, are essential. In some settings, or when research is supported by grants, permissions may be obtained in writing from all those participating. Protection of rights to privacy are assured, and individual participants may be anonymised and not identified' (Psathas, 1995, p.45).

In response to Psathas's view, I show how anonymity was applied at every stage of the data collection. In addition to discussion in the literature, I as the fieldworker have my own criteria for judging which aspects of the research should be considered as sensitive. Indeed, in doing most research one cannot avoid the aspect of ethics and confidentiality, specifically with regard to this AIDS counselling, where confidentiality is in relation to sexuality and death, both of which are regarded as sensitive. Frequently, they play an important role in broadcasting and telling stories because it is taboo but interesting. Thus, the researcher must take this into account when studying them. In my opinion, amongst Thai families, talking about AIDS, sexuality and dying and death in relation to one's sexual scandals and promiscuity, bad luck and cursing respectively. Thus not every one can talk overtly about these. The conduct of this study follows the statement of ethical practice from the British Sociological Association (BSA).

'Where possible, threats to the confidentiality and anonymity of research data should be anticipated by researchers. The identities and research records of those participating in research should be kept confidential whether or not an explicit pledge of confidentiality has been given' (BSA, March 2002).

3.2.1 Protection of confidentiality and informed consent

With regard to the agreement for protection of confidentiality, complete anonymity and confidentiality were promised for participants at all stages of the

study. The document sent to the directors stated that I myself, and both supervisors, had to sign a formal statement of confidentiality and data protection for the period of the research, which was carried for the perusal of any participant. In this agreement, it also stated that if I, the nurses and/or their patients, felt that the matters discussed were too personal or too sensitive, either party had the right to switch off the recording or ask for the recording of the session to be erased. This applied equally to video and audio recordings of interviews. In addition, this agreement included the assertion that some extracts from the transcripts would be reproduced, e.g. in research publications or at scholarly conferences. Recordings, documents and transcripts would be restricted to scholarly use only. The recordings themselves would not be played in any kind of public setting and access to these video tapes would be limited to me and my supervisors. Furthermore, the recording of the consultations and interviews would not be used for any other purposes other than for this study. Audio and video tape recordings would be kept in secure storage and access would be limited to only me and supervisors. Last, the recordings would be kept for the duration of the research study and the subsequent analysis and writing stages. Thereafter the recordings would be destroyed.

The nurses and patients had different ideas about confidentiality. For the nurses, confidentiality was taken as stated in the agreement that data could be used only for academic purposes. For the patients, the confidentiality agreement meant that data would not be used deliberately to broadcast on television because their relatives might learn about their disease status if broadcast. The recruiting procedure for the study involved explaining about informed consent and pseudonyms.

Informed consent: I sought the formal permission of the nurses and patients involved, and their signatures of informed consent. Patients were provided with written information about the study and asked to sign a consent form²² giving their permission and agreement that they were to be recorded. Prior to recording consultation cases, nurses helped me recruit patients. Nurses helped make sure that patients understood the agreement by explaining further about the ethics and confidentiality. Each time a consultation was begun and recorded, a

²² See a consent form for a nurse and a patient both in English and Thai, in Appendix C.

counselling nurse would explain in advance what I was doing. No-one was coerced to cooperate in this study.

The matter of signing consent forms prior to any recording of data can be seen in some of the video recordings.²³ Although some patients might have had little prior knowledge about the protection of rights, this did not mean that they could not come to understand it. Importantly, even though nurses explained about confidentiality and the protection of rights, some patients show awareness of their rights and prudence.

Here are some examples of refusals to be recorded. The first case involves a young male patient who came for the health consultation after his blood test was confirmed to be positive. He expected to work abroad in Taiwan, and as a result he was required to have health and blood tests. When he came to see a nurse for a health consultation, he seemed stressed and introverted. This nurse approached him to be a research case, but he was unwilling to be recorded by video camera and accordingly he said 'no' for video recording. However he gave permission for me to record his voice while he talked with that nurse.

In a second example, in the beginning a female patient did not allow me to record her consultation owing to her husband's presence. However, she had given her informed consent for me to video record sessions when she talked with a nurse without her husband. She confessed that she was not certain whether her husband would be open to others' involvement or not.

As well as the above two cases, a female patient talked with a nurse about her health and her daughter. At that time, she was concerned about her daughter's health because she had heart disease. She cried during the consultation, and then she asked for the nurse to call me to stop recording. Afterwards they expanded their talk a little. These examples provide evidence that patients were not coerced to cooperate in this study.

Pseudonyms: Participants were told that pseudonyms would be used throughout this study to protect the anonymity of medical staff and patients. Nurses helped tell patients that pseudonyms would be used in all transcriptions. The source of the data, location, identity of the subjects etc. would not be

²³ For example, in case no. 25, the patient was illiterate. He used his thumb print in place of a signature on the consent form. As shown at the beginning of the video recording, he was told about informed consent.

identifiable from the featured extracts. Specifically, reference would not be made to any individual person or any individual case in a manner which could be used to identify that person, either in publications or in personal or professional communications.

The protection of rights and confidentiality included keeping all data secure and confidential. The mini DVDs were marked with only the code of the patient and the date and time of recording. As soon as I returned to my accommodation, I inspected the mini DVDs, counselling cassettes and interviewing cassettes. I would check them carefully in terms of the patient codes and that the consent forms were signed correctly. I matched all the recorded mini DVDs and cassettes to details written in the field note book. In the field note book, a schedule of recorded data was designed in which I would write down the code and the name of the patients, the date, time and venue. In addition, all the recorded audio cassettes were copied to provide a spare copy. The data on the mini DVDs were transferred onto VHS cassettes, and the transference of data was handled with care. Last, all the data were transferred onto the computer and thereafter onto CD-roms.

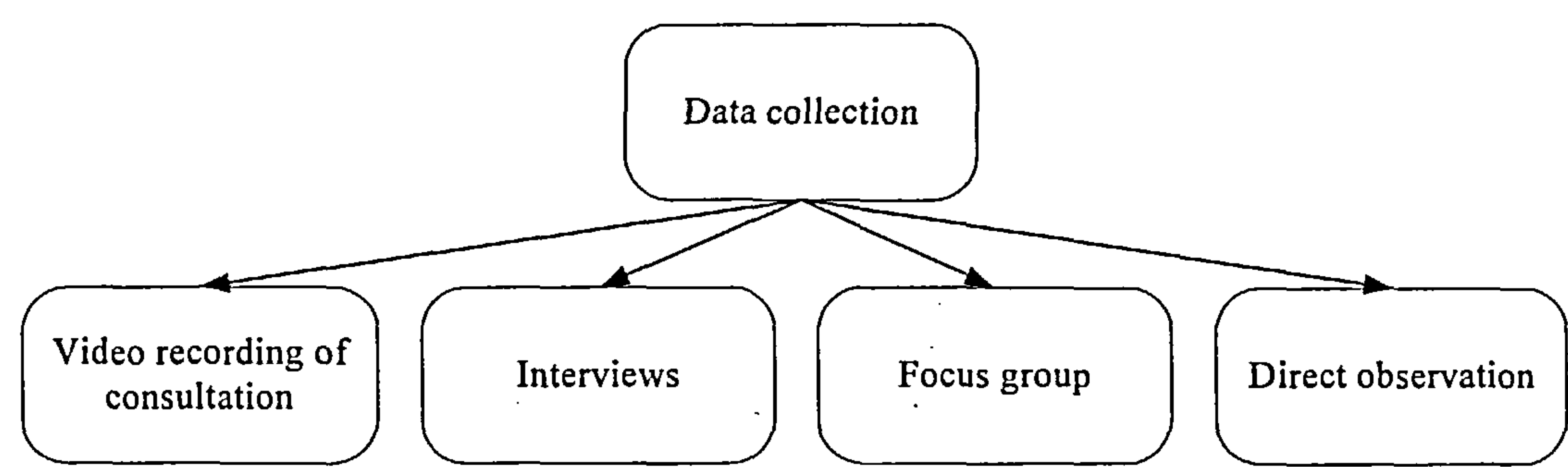
Before participants were recorded during their consultation and interview, they were clearly informed how they were made secure in terms of their protection of rights and confidentiality. I followed the ethical practice of the BSA. These procedures made participants willing to be involved with this study. Medical staff considered this research to be academic. Nurses agreed with patients to use data only for academic purposes. Also, most nurses gave me permission to use data within small groups of scholars, such as in times of presentation in the department or during a conference, and for the purpose of academic development.

However, if I or anyone else concerned found the subject too sensitive, they recommended ways to address that problem. They stated that either pictures of the consultation could be rendered unclear or the patients' face should be hidden. This was so that nobody could remember them. Having informed people about the protection of confidentiality and informed consent, I collected data strictly according to these ethical practices.

3.3 Data collection

I applied four main modes of data collection as shown in diagram 3.

Diagram 3. Four main modes of data collection



3.3.1 Video recording of consultation

The recording of consultations between nurses and patients was the most important mode of data collection; I used a video camera to record these consultations.²⁴

The main reason for video recording is simply because it fits what I investigated. I wish to uncover how HIV/AIDS counselling is conducted by looking at the way in which the nurse and patient interact both in verbal utterances and body movements during a face-to-face interaction. Peräkylä (1995, p.29) points out that a video recording offers more advantages by stating that ‘[i]n face-to-face interaction – such as counselling – gaze and body language are available, and therefore the analysis has to take them into account’. He also states that in his study of AIDS counselling, ‘the analysis of gaze and body posture has a subsidiary role’ (ibid). Drew and Heritage (1992, p.5) state that ‘[i]nsofar as recorded data from institutional settings can be subjected to repeated inspection which can enhance analytic treatments ranging from the interpretative to basic forms of quantification, an opportunity exists to bring new insights to traditional sociological analyses of institutional settings with additional data and with new and powerful investigative techniques’.

²⁴ See table of video consultation data in Appendix B.

The transcripts are used in conjunction with audio and video recordings. Lee (2000, p.53) points out that '[o]ne advantage of video is that it captures, and retains for analysis, a great deal of detail'. Conversational analysts could more fully get access to the verbal and non-verbal communication which they expect to investigate. A video recording can record potentially crucial details of pauses, intonation, overlaps and other non-verbal aspects. In other words, it improves results in producing transcripts and the upcoming data analysis. The use of video was apparently accepted in my study because the confidentiality and the protection of rights played a part. In addition, the counsellor and patient have freedom to talk about things which concerned the patient without my presence.

The nurses made appointments with patients in advance so that each case could be properly recorded. The video camera was mostly used to record consultations in conjunction with a contemporaneous audio recorder so that the data would be secure and proper. Prior to all consultations, I would set the video camera on a tripod in a corner of the counselling room. The camera could be seen clearly while the recording was taken. Before recording, I checked carefully as to whether I had inserted a mini DVD and had an adequately sensitive microphone because sound was also an important component in the recordings. I had to test my camera to see whether it was sufficiently high enough to be able to capture good pictures and movements during the consultations. It must be borne in mind that I had to appropriately set a camera frame so as to obtain coverage of the full range of movement by all participants because occasionally some of them adjusted their position while they were talking. For example, some nurses and patients leaned on chairs. After the video camera and other equipment were set up, an audio recorder with two 60 or 90 minute blank tape cassettes were usually put on the counselling desk. The resulting tape cassette would be given to a counselling nurse for transcription.

In the counselling room, I would be present at the beginning of the consultation in order to switch on the research equipment. Windows were open or closed as was appropriate. Sometimes, the light had to be switched on to render the counselling room properly illuminated because over brightness or over darkness affected the quality of the recording. In addition, I usually switched on the electrical wall fan to keep the counselling room cool. The temperature and atmosphere in the counselling room had an influence on the emotion of both

participants. Having done this, I exited the room. My presence in the counselling room during a consultation was absolutely impossible because the consultations were extremely sensitive and confidential.

On most occasions, I would sit outside in front of the room. I had to sit near the room because I might be required to stop the recording immediately if the consultation was found to be too sensitive. As stated earlier this requirement was part of the informed consent. Second, I stood in front of the counselling room in case I was required to help the counselling nurse in any way or bring things into the counselling room. For example on one occasion, the nurse gave me a sign to walk into the room and I was asked to bring some drink into the counselling room for a monk.²⁵

The number of counselling cases: Prior to entering the settings, my supervisors and I only expected to collect half as many counselling cases by means of video recording as were actually collected because permission for data collection had been refused at my first attempt. Consequently, it was difficult to estimate the expected number of cases to be collected. Any expectation was exceeded because 43 counselling cases were recorded by video camera and 9 by audio recorder.²⁶ The participants were 9 female health care professionals in the company of different HIV patients. The number of patients appearing on the

²⁵ Of course, my presence in a counselling room was seriously prohibited. However, serving a drink was allowed by the patient and counsellor. The counselling room at this hospital had a glass window out front, as shown on the video. Therefore I could see in at all times during a consultation. I realised that I was needed because the nurse gave me a sign by waving her hand. However, I should point out that normally nobody would be allowed to be there during a consultation. I should explain further that the nurse herself should not serve the drink because she was female and this would have contravened strict regulations associated with monkhood. Of course while I served the drink, talking was paused. The interaction was continued after I left the room. The drink was required because the patient had missed breakfast to travel to the consultation. He could have sought health consultation at a closer hospital but he did not want to do so due to fear of stigmatisation. According to the Buddhist regulations, monks must ask for food to be given by others and they cannot buy anything. He could not eat anything given by others after 12.00 a.m. and he usually consumed foods twice a day-breakfast and lunch. Although the chief nurse informed me that the consultations normally took no more than one hour, in this case, the consultation took longer. The counselling session was terminated by 10.00 a.m. and the video camera had stopped running after one hour and six minutes. I considered myself lucky because the additional audio recorder recorded the whole session.

²⁶ Audio recording was used for any consultation which could not be recorded by a video camera. Sometimes this was because patients preferred it to a video recording. However, sometimes, the nurse, herself, would decide to use an audio recorder without any request from the patient because she considered the session too sensitive. For example, one elderly patient of approximately 60 years of age had been admitted outside the ward because there was no bed available on the ward. For this subject, the use of a video was not appropriate because it would have been too obvious to the staff and others walking by her bed.

video is greater than 43 because some counselling sessions were conducted with couples and in some cases patients' children were present.

Because of the qualitative nature of this research, 43 cases are sufficient for this study. But this would not of course qualify for quantitative study because this requires several hundreds to prove representative. Forty three cases seem to be a small number. But this number offered overwhelming details of talk. It would be impossible to handle larger numbers in the same level of detail.

The type and practicality of the recordings: The cases featured in this study are not fully representative of every type of counselling in the hospitals. The type of recording can be divided into four groups as follows:

The first group may be called 'single patients' because one patient, either male or female was recorded.²⁷ The backgrounds of most of the patients were different. For example, some patients were homosexual and one of them used to work as a male prostitute. One male patient had been diagnosed as schizophrenic, one patient was an old lady. One patient was a Laotian who had crossed the frontier to work in the northern part of Thailand some twenty years ago before.

The second group was couples. I recorded three couples, two of them on video where both of them were HIV positive. One couple were recorded where the husband was not HIV positive. Amongst these, one couple's child was present during a consultation. They all came to see the nurses for consultation together.

The third type may be called the 'kinship case', because there was one case who were brother and sister. The sister, who was younger, was infected with HIV before her elder brother. They came in for consultation together.

Fourth, I recorded some patients in the company of their children during a consultation. This fourth type of cases are a subset of the other three. All the children were HIV positive.

Most patients were infected as a result of two main causes. Most of them were married women. They contracted HIV as a sexually transmitted disease. Their infection relates to the gender inequality which currently exists in Thai society. Women in some developing countries lack the opportunity and empowerment to negotiate regarding sexuality with their husbands (see Akeroyd, 2004, p. 96 and Hunter, 2005, p.43). They could not tell their husband to use

²⁷ In some sessions, the patient's relative was involved with counselling for a short time.

condoms if they did not have any clear evidence to prove the risky behaviour of their husband.²⁸ Some were infected with HIV by sharing needles because they were drug users.

3.3.2 Interviews

The main reason for conducting in-depth interviews was to broaden my knowledge of the holistic care of AIDS patients and to integrate some aspects of the ethnographic data arising from nurses' opinions in CA data. Collins (f.c.) shows the importance of integrating interview data in conversation CA by stating that '[h]owever, integrating interview data in conversation analysis has potential to illuminate analyst's interpretations, and to enhance professionals' contributions from analysis through to dissemination'.

Interviews with counsellors: As this study focuses on how theoretical knowledge is applied, I interviewed nurses about their stock of knowledge. For interviews with counsellors, four themes were designed each comprised of between 4 and 6 sub categories. The first theme is about the training and theoretical knowledge which most nurses had received. Second, most nurses were expected to reveal something about what achievements they expected from the counselling. Third, all nurses were asked to give examples of counselling sessions which had led to some difficulties. Last, they were given a chance to elaborate on how they viewed their achievement so far in counselling. Interviewing nurses at different times held some advantages. Once I finished interviewing the first nurse, there were a number of interesting themes emerging from the interview. I could then explore some of these themes further with the next nurses. The interview data is integrated with the CA data by showing examples. Two kinds of reports arose from interviews with counsellors. They reported about patients' communication style and their own communication strategy.

The first example shows the patient adopting a passive role in talking. The nurse was aware of that passivity. However, the interview data did not cover how this nurse realised such passivity, as shown in the extract.

²⁸ My video data consists of 33 married women; some were widows, and some had remarried.

- | | | |
|----|-------------|-----------------------------------|
| 1. | Researcher: | Do you think the counselling |
| 2. | | theory can be really applied to |
| 3. | | practices? |
| 4. | Nurse: | No, not really because people in |
| 5. | | our area are recipients. They did |
| 6. | | not interact continuously. |

The interview data show that the nurse realised the passivity of the patient as the communication style of the patient. This was shown in interaction simply because most patients did not initiate particular topics and their turn sizes were small.

The next three examples show a communication style used by nurses. The first illustrates a nurse being suspicious about the patient's sexual conduct, causing her to probe further for more information.

- | | | |
|----|-------------|------------------------------------|
| 1. | Researcher: | anything did not follow |
| 2. | Nurse: | about condom |
| 3. | Researcher: | what kind of account did they |
| 4. | | give? For not using |
| 5. | Nurse: | they said they had not got used to |
| 6. | Researcher: | what would you say to them then? |
| 7. | Nurse: | would elaborate them regarding |
| 8. | | disadvantages if no condom use |

The data show the nurse encourages her patient to use a condom by explaining the disadvantages and advantages. This was also found in interaction in the fact that the patients might live longer with their children if they had safe sex by using condoms.

The third example shows how the Thai counselling is shaped by discussion of Buddhism. This was seen in most counselling sessions. The data from interview indicated that most nurses referred to the application of religion in their discussions with patients. In addition, it also shows the preparation for dying. The nurse stated that they would discuss death and dying with patients when they were not at the stage of dying or seriously ill.²⁹

- | | | |
|----|-------------|----------------------------------|
| 1. | Researcher: | How was it? |
| 2. | Nurse: | would talk about consciousness |
| 3. | | remind them that was suffering |
| 4. | | then they would not struggle. |
| 5. | | Indeed, preparing them for this |
| 6. | | was not conducted when they were |
| 7. | | in acute condition |

²⁹ See Chapter Eight, and also Peräkylä (1993).

8. Researcher: right³⁰ right
9. Nurse: we would discuss it before

Fourth, the nurse addresses the gender issue in interaction. She reported that she would touch most female patients when they were crying, but would not do the same with male patients.

1. Researcher: When they came here and cried?
2. Nurse: I would let them cry a bit then
3. give them face tissues let them as
4. it was a technique of consoling
5. them as normal we had known and
6. been close to each other, but not
7. for men. There was rarely men who
8. cried. If there were men crying, I
9. would give them face tissues. If
10. women, I would touch them and
11. listen to them then they would
12. speak it out.

The interview data highlighted aspects on which I could focus the research. In the above excerpt, the nurse reported about gender in interaction. It is true that nurses touched, stroked and caressed the females and male homosexual patients identified themselves as feminine more often with male patients. This application is a communication strategy used by the nurse.

In summary, interview data can make clear what counsellors had intended to achieve. Similar aspects were found in data in interaction. For example, counsellors believed that most patients were passive. Consequently, they engaged in talk by initiating topics. Interview and CA data can be handled simultaneously to support the interpretation of data. The interview data were used to prioritise themes when analysing interactional data. In addition, these data also make the application of theory clearer in professionals’ practices.

Interviews with patient: The objective of the interview was to disclose the ways in which patients find the counselling useful. There were ten main questions

³⁰ The word ‘right’, as used in this study, sometimes serves as a polite particle in the northern dialect. It is used to mean ‘yes’ in Thai conversation. This kind of utterance is different from the particle use in the language of central Thailand. The use of this particle in Thai conversation can identify the gender of a speaker. In this context, the ‘right’ particle refers to a female speaker because the patient is female. In Thai, a male speaker uses the word ‘khráp’ as a polite particle. Here, it is important to note that throughout this study, the word ‘khráp’ is also replaced by the word ‘right’. The purpose for explaining the use of ‘right’ as a polite particle is to show the politeness of the speaker, and importantly this word can represent the power relationship between the speaker and the audience in Thai conversation. For more details of Thai particles, see Smyth (2002, p.126-129): Chapter 10 on sentence particles.

expected to be used interviewing patients. For example, questions on how and why the patients came for consultation and what the counselling meant to them had to be used. In addition, they would be asked what they had understood from the nurses' talk with them. My aim was to discover how they understood the advice given. If they did not understand they could ask the nurses. My interview guidelines included giving patients the chance to ask any questions they might have. Moreover, I sought to ascertain what concerned most patients practically, emotionally, spiritually and medically. I had to find out what kind of difficulties most patients had during consultations and how the counselling helped them. Last, interviews included a question as to whether they were a member of a group of people living with AIDS or any network for patients. These were principally used to interview the counselling nurses and patients. However, the exact format on the interviews depended on the context during the interview. Occasionally, some key themes emerged from the interview, and it was useful to seize on them to be gradually expanded for more relevant information.

Some of the participants were not interviewed on the same day as their counselling because they were not available. Consequently, they were interviewed at a later date at their homes. One Laotian patient was interviewed at his temporary residence, which had been built for him and other workers. In one case, a male patient was interviewed at a place reserved for HIV patients. In this case, the interview could not be done at his house because he was too weak to talk at the time at which I visited his home. The nurse who took me to his home implied that he might have a short life span because nobody took care of him. He was given some food to target malnutrition. He decided to move to the care home, called the house of hope, because it was cleaner than his home and there was someone to take good care of him. In my view, it should not be dubbed a 'hospice' because, as well as terminally ill patients, there were patients at every stage of infection living there. I was able to get access for the interview because a nurse asked for formal permission from the administrative staff. The nurse and her husband drove me to visit him early one day.

Some patients would cry during the interview as the discussion was sensitive, they were emotional and they were aware of dying. Some nurses stated that it would be better if I could interview patients as quickly as possible because they might emigrate to find work, or some might become worse. The interviews

could cause trouble for patients. For example, the chief nurse and I went to visit a patient at her home. We had gained permission to approach her, but on that day I could not personally interview her because her son was present. Her son was an HIV carrier but he did not know about his own infection and consequently the patient stated that it was most important not to let her son know of any concerns.

In-depth interviews with patients illuminated the relationship between HIV/AIDS and legal abortion. One patient was recommended to have an abortion if she was infected with HIV because the new born child may have a chance of being infected with the virus.³¹

Interviews with other nurses: I interviewed one nurse whom I met when both of us participated in the counselling training. In addition, I also interviewed two nurses who were working in Bangkok. These other nurses were interviewed on the same subjects as the counselling nurses. I had seen the first nurse on television while I was staying in the research setting. She was on a programme talking about how she dealt with HIV children. She narrated how she was doing counselling and how she coped with a dying child. I contacted the nurse through an address shown on the screen during the broadcast. The second nurse was a colleague of the first nurse and I interviewed her as an offshoot of interviewing the first nurse.

Interviews with doctors: Three doctors were interviewed. I chose to interview the director of a hospital with 60 patient beds simply because I had recorded most counselling cases in this hospital. My interview guidelines focused on the policy on AIDS and how nurses were encouraged or supported to continue the counselling job. One important aspect was that there was not a counselling room in his hospital. I sought an answer for this aspect on this issue, which was on my mind while I collected data. Principally, all hospitals should have a specific counselling room or private place in accordance with the training course held by the Thai Ministry of Public Health. UNAIDS points out that HIV/AIDS

³¹ These data were based on ethnography. One patient had decided to have an abortion. Her husband agreed with her decision. After having the abortion she was informed that the abortion was seemingly successful. Surprisingly her stomach became bigger and bigger while she was working, which meant that she was continuing the pregnancy. Thus she came back with her husband for a consultation with the doctor. Unfortunately, it was too late because her pregnancy exceeded the acceptable time for it to be terminated. As a result she had to carry on the unwanted pregnancy. Finally, she gave birth to a baby boy. The baby was too young to be tested for HIV; his blood will be tested when he is one and a half years old.

counselling should be conducted anywhere that counsellors and patients can ensure confidentiality and they can bring topic of sexuality, death, dying or personal matters into discussion (see UNAIDS, 2000d). In this area, an association between one's privacy and a place should be shown in relation to a statement of WHO. WHO (1993, p.5) states that 'HIV counselling can take place almost anywhere, privacy is an important consideration'.

In addition, I interviewed another doctor who was currently working in a hospital in Bangkok. He had got involved with HIV counselling and other issues related to AIDS early in the epidemic. He was well-recognised as a speaker on AIDS counselling nationwide. During one training course arranged by an office of the Ministry of Public Health he was referred to several times. He is the author of an important technique for HIV counselling. He gave me an overview of AIDS counselling in Thailand, and at the same time he narrated other promising aspects concerning AIDS.

I interviewed another doctor whom I met in the research settings. This doctor was important amongst medical staff in the area. He was well-known and respected amongst medical staff at the Ministry of Public Health in Thailand. He said that he did not agree with some of the ethics of medical care. He went on to argue that medical staff should have the right, to some extent, to break the news to a patient's spouse that the other was infected with HIV. He added that it was seemingly done for the protection of human rights, but that we were going to let someone get into trouble. Interestingly, his idea was expressed in relation to one theme in interaction. One female patient blamed a counsellor for her infection because this counsellor did not inform her that her fiancé was an HIV carrier. She then became a victim after she decided to marry him.³² Analysis of interaction also therefore provided a detailed account of this aspect of ethical concern and confidentiality reported by co-participants.

Interviews with patients' husbands: Some patients lived with their spouse, although their spouse was not HIV positive. One aspect expected to be illuminated by interview was how they lived and socially interacted. One man lived with an HIV positive wife and child. Amazingly, he was still negative even

³² This incident was from case no. 08. The counsellor, who was a psychologist, confessed to me during an in-depth interview that she felt sinful and regretful up to now about this incident. The sole reason for not revealing the man's status given by this counsellor was that she did so in accordance with the ethics of medical care.

though he had penetrative sex with his wife and his wife became pregnant as a result. A counselling nurse confirmed his negative status with me after he had blood tests three times. At first, he rarely used a condom when he had penetrative sex with his wife. Interestingly, he stated that he loved his wife and he had no inclination to leave her behind. However, he confessed that it was really stressful for him to look after his wife. In this area, the interaction on video between him, his wife and a nurse can precisely and clearly represent how stressed he was.³³

Interviews with patients' wives: One nurse approached a young woman to get involved with this study who was not HIV positive. She was the wife of a dead HIV patient. She revealed that she was stressed because she had been discriminated against by her neighbours. This is the main reason why she had to come for a consultation. She stated that she would not blame her neighbours if she was really infected with HIV.

Interviews with the husbands of the nurses: The husbands of the nurses stated that they had an understanding of their wives' routine work, and they also comprehended how this might lead their wives to become stressed. As a result, they revealed that the encouragement and emotional support given by them were necessary and valuable in their wives' work. They confessed that their support could decrease the 'burnout' rate of the nurses.

Interview with a monk: One aspect about which he talked was the issue of dread. He told how his family had coped with the imminent death of his sister. He was a monk, and subsequently he understood and saw death differently in comparison to other people. He accepted that nobody could help his sister and he regarded death as natural. One thing he contributed to his sister was to convince her to acknowledge her hard circumstances and finally to die peacefully. He stated that AIDS had been extremely harmful to his family.³⁴

In summary, interview data given by participants can cover a wider range of counselling. I was provided with information about the holistic care of AIDS. In addition, I was provided with clarification of connected medical terms such as

³³ One question which this study cannot answer is how he is still negative. On video counselling, the nurse alluded to whether he still used a condom when he had sexual relations with his wife.

³⁴ He reported that his brother in law had also died recently from AIDS and this disease was related to discrimination. He had taken all of his sister's clothes as a donation to the hospital, but he stated that he was not certain whether others would willingly use these clothes because their previous owner had died from AIDS. He added that the people in the area were misinformed about HIV infection.

CD4, antiretroviral drugs or opportunistic infections. This was also referred to in some counselling sessions. In addition, interview data could be integrated with data from interaction in some aspects. This illustrated the contrast between what the professionals intended to achieve and what they actually did in practice. However, the ethnographic data helped me understand some aspects quickly. But they were not integrated in analysis with the data from consultations as the analysis of talk-in-interaction was conducted in each turn.

3.3.3 Focus group with patients

Focus groups are predominantly used in qualitative Thai research. Remarkably, the manner of applying this method for data collection seems to be one-to-one interview. For example, Pattaravanich (1998) reported research results regarding sexual opinions and behaviour amongst adolescents in one commercial college in Bangkok. A focus group was one of the data collection methods. In addition, Podhisita (2004) published his book on qualitative research. He illustrated a focus group as one important qualitative research method in Thailand. He did not point out whether a focus group as interaction used to be conducted. He referred roughly to a focus group in the manner of interaction. This study regards focus groups differently from that in the Thai context. More specifically, I used a focus group in my study as it is interactional. Wilkinson (2006, p 52) stated that '[f]ocus groups are not simply group interviews'. Wilkinson (2003, p. 185) points out that the moderator should facilitate group discussion and encourage participants to interact with each other.

I organised a focus group in co-operation with some nurses.³⁵ Prior to the discussion, patients gave their informed consent for video and audio recording. I asked the leader of the patient group to be my assistant. He helped me inform patients what I planned to do and to discuss this with them. In addition, he kept an eye on the video and tape recording and he and another patient helped raise and write issues on flip charts. Generally, they exchanged views on how useful they found the counselling. In addition, the issue of what they hoped to obtain from medical staff and hospitals was raised. In terms of the technicalities of the

³⁵ Prior to conducting the focus group, the nurses helped confirm some patients' participation and helped organise the venue and some stationery.

focus group, I facilitated them by letting them share experiences and ideas freely. Doing so led me to realise that each patient interacted with each other as if they were talking in a session with their friends.

Here, I show how patients interacted with each other in sharing opinions and experiences on the topic of confidentiality. I analysed the data from the focus group as an analysis of interaction which differentiates from the analysis of focus groups in most Thai research, as stated by Wilkinson (2006). Wilkinson (2006, p.52) illustrates that '[w]here interactions between focus group participants are quoted, they are typically either not analysed at all, or analysed solely at the level of content, rather than in terms of their interactional features'.

At 16:35 minutes, one patient raised the topic of how infection was revealed by a home visit from medical staff. Medical staff had visited patients at homes without permission even though patients were trying to keep their infection confidential. I continued this interaction with other patients after the topic was initiated, as shown below.

[Focus Group – 16:35] [VIDEO]

[There were 15 patients involved in the session.]

- | | | |
|-----|-------------|--------------------------------------|
| 1. | Researcher: | then ((pointing)) |
| 2. | Patient 1: | ((coughing)) ((coughing)) |
| 3. | Researcher: | your recommendation |
| 4. | Patient 1: | ((coughing)) ((coughing)) |
| 5. | Researcher: | think that what they should do (.) |
| 6. | | mean (.) will visit us |
| 7. | | ((stretching hand)) at least |
| 8. | Patient 1: | ((sniffing)) |
| 9. | Researcher: | for our neighbours (.) in case |
| 10. | | who still not open |
| 11. | Patient 1: | ((sniffing)) |
| 12. | Patient 2: | ((tossing head)) |
| 13. | Researcher: | they will not have effects (.) |
| 14. | | what do you think? |
| 15. | Patient 3: | at least (.) we have to know |
| 16. | | before |
| 17. | Researcher: | ((turning to patient 3)) |
| 18. | | → ((nodding)) want to know before= |
| 19. | Patient 4: | → =must ((stretching hands)) tell us |
| 20. | | → to know before |
| 21. | Researcher: | ((nodding)) |
| 22. | Patient 3: | → whether [we will let them go |
| 23. | Patient 5: | → [whether [we will let |
| 24. | Patient 3: | → [whether will let |
| 25. | | go |
| 26. | Researcher: | ((writing down)) |

27. Patient 6: ((turning to patient 4)) like-
 28. Patient 5: → [ask them whether they are open
 29. Patient 6: → [that would visit at home of
 30. (name of other patient) ((pointing
 31. back))
 32. Patient 5: whether will let others visit
 33. ((stretching hand))³⁶ enter the
 34. house
 35. Patient 3: will let them visit
 36. Researcher: uh::
 37. Patient 6: did not let enter the house
 38. of (name of AIDS project)
 39. Researcher: how about pii³⁷ ((name of the
 40. patient 6)
 41. (0.1)
 42. Patient 5: that ((raising arm)) previously
 43. there were a lot of friends (.)
 44. infected (name of AIDS project)
 45. would visit ((tossing head))
 46. them at houses (.) they ((slightly
 47. shaking head)) did not let them in
 48. the house (.) as they had not
 49. accepted it yet
 50. Researcher: → orr:: there was patient (.) ill
 51. → (.) they did not let in
 52. Patient 5: → no she was not that ill (.) she
 53. → still looked normal
 54. Researcher: ((nodding))
 55. Patient: at first (.) she went for (.)
 56. checking (.) she did not know (.)
 57. she was pregnant
 58. Researcher: ((nodding))
 59. Patient: but now she has passed away

This topic concerns most patients. Patients showed the same opinion that they should be informed in advance of any visits. After the patients reported their views, I as a moderator did not show agreement, but I produced my turn by repeating the same utterances, as shown in line 18. I did this in order to make sure I had understood the prior turn correctly and to control turn-taking.³⁸

Patients agreed that home visits were possible if they gave permission. The data seem to show that patients were aware of their own rights. This is seen in lines 19-20 as one patient uses the utterance 'must ((stretching hands)) tell us to know before'. Patients shared opinions and completely agreed with home visits with full permission given by patients by using overlapping utterances, as shown in lines 22-24 and 28-29. In addition, my turn was corrected by a patient. The

³⁶ The patient stretched his hands in and out quickly.

³⁷ I addressed the patient by using a word 'pii' because she was older than me.

³⁸ Myers (1998, p.87) pointed out one of the features of most focus groups that particularly affects turn-taking is that the moderator can intervene to control turn-taking.

patient did not agree with what I said in the prior turn in lines 50-51. The patient corrected me by saying what I mentioned about the status of another patient. In lines 52-53, she corrected that the patient to whom I referred still looked normal; she did not look like a patient.

Strikingly, the content in the focus group relates to findings in counselling sessions. Counsellors were aware of confidentiality. Before they visited patients at home, they would ask for permission from patients by using utterances ‘Could I visit you at home?’³⁹

The focus group offers the interactional scene. Patients did not reserve the role as answerers in one-to-one interviews, which was typical of most focus groups in previous Thai research. I as a moderator facilitated them to continue interaction freely. At the end of the session, they were expected to answer two final important questions. The first question was about what they worried about the most. The second question was asked in order to address the issue of dread. They were asked how long they expected to live with their families. All of the answers given were different: however, the main conclusion was that they worried about their children, and more specifically that they required money for their children’s education. In terms of the second question, there were a number of different aspects on which they elaborated. For example, some patients did not know how long they could expect to live. They would try to do everything in their children’s best interests in the meantime. Some patients stated that they simply expected to live with their children for as long as possible. Some showed that they expected to live longer because they were not showing serious symptoms. Some of them stated that they believed that their life spans would definitely be long, while others could accept imminent death. Last, they expected the scientists and doctors to discover new medicines which could cure the virus. In addition, I also asked them for any queries they might have.

In summary, the focus group in this study was analysed in interactional mode. This made it different from previous research, which regarded focus group data similar to a one-to-one interview. The data showed how patients shared their opinions in interaction by their own accounts and techniques rather than describing their ideas.

³⁹ See Chapter Six on disclosure and confidentiality.

3.3.4 Direct observation

The recordings in the field note book were input on a day by day basis. All data relating to the scenes and what was seen, felt, and spoken by relevant persons such as the nurses, their husbands or patients and their relatives had to be written down as quickly as possible. Emerson, Fretz and Shaw (1995, p. 46) point out in this area that '[t]he most urgent purpose is to record experiences while they are still fresh'. They also state that the researcher should remember the scene rather than remembering the particular words used in the field because the remembered scenes would lead the researcher to be able to recall words and utterances used by participants. However, remembering the scene might not cover other aspects such as linguistic matters in words. For this particular study, field note writing was important owing to its varied benefits. One example came from a consultation between the chief nurse and a monk. The field note recording was necessary for this case because the video camera had stopped running before the consultation was terminated. As I stood in front of the counselling room, I could observe what happened. I witnessed an important scene where the monk, who sat with his back to me, was chanting to bless the nurse, which the nurse acknowledged.⁴⁰ In my opinion, this could influence the counselling because the patient was of a higher social status than the counsellor, according to Thai social structure. I also wrote down some events in a field note book.⁴¹ In addition, I took photos with patients and nurses. Before I left the site, I left the photographs of patients with a nurse.

In summary, ethnographic data and information broadened my horizon of the holistic nature of AIDS care. I could learn how this disease was tackled and how patients were given treatment and support. These data also allowed me to understand medical terms and techniques in AIDS. I integrated interview data with CA data. I utilised a focus group for data collection, but it was analysed naturally based on interaction. I did not use all these data in the core data analytical level. In other words, the data from interviewing and other methods were not being integrated in analysis. But I learnt greatly from them. The most

⁴⁰ I could see this scene as the counselling room had glass windows.

⁴¹ The video camera was also used to capture some of the naturally occurring activities in hospitals such as the working hours of the nurses on the ward as well as the working of the HIV patient groups. In addition, it was used to record some unexpected activities outside hospitals such as the cremation of one HIV patient and the AIDS campaign in the temple.

useful and important data for my study are interactional facts based on natural occurrence, which I obtained from counselling sessions.

3.4 The reliability and validity of the field data

Some Thai researchers were overwhelmingly dominated by the paradigm of positivism, and it led them to test hypotheses. One aspect of this is that they had to test the reliability and validity of questionnaires and data used. More specifically, qualitative researchers sought for a credible strategy to prove the reliability and validity of data within their research. Some tried to make the association between reliability and validity in the same way as quantitative research. For example, they tried either to determine an adequate sample size or to find some tests on the validity of their open-ended interview guidelines or questionnaires. My study is qualitative, belonging to the branch of ethnomethodology. It is a methodology used for investigating the naturally occurring interaction in CA. In my view, some discussion on the reliability and validity should be done in relation to the field data.

Schwandt (2001, p.267) stresses the importance of validity by stating that '[v]alidity is an epistemic criterion: To say that the findings of social scientific investigations are (or must be) valid is to argue that the findings are in fact (or must be) valid is true and certain'. During my field work, I could cross check between data from other sources and data from the nurses. Here, I would posit this as confirmation of validity because it is a true sentiment and this finding accurately represents the phenomena of which I had direct experience during my field research. Integrating interview data with CA data can demonstrate validity. In addition, to some extent, the content in focus group in interaction, not one-to-one interview, also demonstrated validity.

Reliability is important as well as validity. Specifically, within my conversation analytic research, the reliability of the data is high when recorded on tape, video and in transcripts. With respect to reliability, Peräkylä (1997, p. 203) states that '[i]n conversation analytic research, tapes and transcripts are the 'raw material' comparable to ethnographer's field notes'. Accordingly, the

quality of tapes and transcripts has important implications for the reliability of conversation analytic research. Atkinson and Heritage (1984, p.4) point out this by stating:

'The pursuit of systematic analysis thus requires that recorded data be available, not only for repeated observation, analysis and reanalysis, but also for the public evaluation of observations and findings that is an essential precondition for analytic advance'.

My study data recorded on video without having been edited, unlike films or most television programmes, were natural. On this subject, most conversational analysts agree that video recording could offer the highest reliability because it captures the social world as the raw material for data analysis. In addition, most aspects of the video recording can be repeatedly inspected for the purpose of ascertaining its reliability.

In summary, the data collection was conducted in accordance with ethical standards. The main mode of data collection was video recording of counselling sessions. Ethnographic methods such as interviews, focus group and direct observation were used to supplement data collection. However, the data in interaction, based on naturally occurring talk, was the core data to be analysed. In addition, I chose to study the themes I wished to highlight, not those counsellors wished to highlight. Consequently, this did not affect the technique of data analysis in consultation. These issues mean this study must use a methodology which can uncover the way in which the nurse and patient interact. CA thus fits such an intention.

3.5 Methodology

While talking to research participants, I found that the interview data given by nurses and patients not only reflected the reality of AIDS care and associated phenomena, but were also an interesting subject for analysis in their own right. When I looked at the data from consultations along with ethnographic data such as how the nurse conducted the process of advice-giving or dealt with delicacy or

awkwardness in some areas, such data were able to provide support to one another. So I came to the conclusion that, as well as recording consultations, I should collect data using other conventional qualitative methods such as in-depth interviews, focus group and participant observation. My initial intention was changed as I wished to apply pure CA to study HIV/AIDS counselling. My study was thus a combination between CA and ethnography⁴², but the primary methodology was CA. In this section, I provide information about CA and the combination of CA with ethnography. I then show how the CA approach is applied to my study. Last, the distinctive characteristics of CA in comparison to other qualitative methods are shown.

3.5.1 Brief account of CA

The methodology of CA and its understanding of interaction as being the primordial site for study of language views language as social actions, rather than as a medium of communication (see Sacks, Schegloff and Jefferson, 1978; Brown and Yule 1983; Levinson, 1983; Atkinson and Heritage, 1984; Wootton, 1988; Drew and Heritage, 1992 and 2006; Buttny, 1993; Drew, 1994 and 2005; Clayman and Maynard, 1995; Heritage, 1995; Psathas, 1995; Hutchby and Wooffitt, 1998; Silverman, 1998; Jaworski and Coupland 1999; ten Have, 1999 and 2001; Heinemann, 2003; Wooffitt, 2005 for further description of CA methodology).⁴³ Pomerantz and Fehr (1997, p.65) pointed this out by reference to Austin (1962), who 'proposed that language not only is a means of representation but also is used to perform social actions, such as making a promise'. CA views language as a means of engaging in social life. The way in which CA is applied is by looking at the detail of interaction. CA is a distinctive methodology focusing on the recording of naturally occurring data. CA can be used to find patterns,

⁴² See Maynard (2003) for more detail about CA and ethnography in Chapter Three on Conversation Analysis and Ethnography: What Is the Context of an Utterance?, pp. 64-87.

⁴³ CA was started by Sacks and his co-workers, especially Emanuel Schegloff and Gail Jefferson, at the University of California during the 1960s (Peräkylä, 2005, p.875). CA is a branch of ethnomethodology. As this word is new to the Thai research community, I should give more detail here. Ethnomethodology refers to a study of the methods used in society to construct and give meaning to their social world. Ethnomethodologists do not agree with the existence of social order in society. But such existence of social order depends on the people making sense of it and think as it is (see Coulon, 1995; Garfinkel, 1967 and Heritage, 1984 for further description of ethnomethodology).

structures and practices in conversation. Peräkylä (2005, p.875) states that 'CA is a method for investigating the structure and process of social interaction between humans'. There are some basic concepts or generic practices that underpin CA's exploration of the patterns, structures, and practices that are to be found in conversation. As CA can be widely used for broad range of applications, I show some particular concepts which relate to the data analysis of my study.

Turn at talk or turn taking: Turn taking is the most basic form of organization of conversation (see Sacks, Schegloff and Jefferson, 1978, and Drew, 2005). The organisation of turn-taking is simply in that people will design their turn with respect to how they have understood the prior turn. Thus, when talk is examined for how it is organised, each turn has to be analysed because the next turn is produced in response to the prior turn. 'What an interactant contributes is shaped by what was just said or done and is understood in relation to the prior actions' (Pomerantz and Fehr, 1997, p.69). The unit of analysis in conversation is a participant's turn at talk. In this study, the main mode of data collection was video recording of nurses and patients. As this study does not focus on the practices of turn-taking, I analysed the data by looking at what happened in each turn. To analyse each turn, we look at everything in it, before and after it. We cannot consider isolated sentences or utterances because each sentence and utterance is produced in connection to the prior or next turn (see Heritage and Atkinson, 1984, p.5). They stress the importance of turn-taking and sequences by stating:

'For conversation analysts, therefore, it is sequences and turns within sequences, rather than isolated sentences or utterances that have become the primary units of analysis. This focus on participant orientation to the turn-within-sequence character of utterances in conversational interaction has significant substantive and methodological consequences' (Heritage and Atkinson, 1984, p.5).

Turn design: We produce our turn design in response to the prior turn of others. Heritage (1997, p.170) states that there are two aspects regarding this turn design.

The first is the action that talk is designed to perform. At this point, we look at the speaker's selection of which action to conduct, how it appears, and in

which turn. In other words, some actions, such as an invitation from one speaker to another should not be given to the other in a turn where he or she is speaking, but will be mentioned in the next turn.

The second is the means that are selected to perform the action. In other words, why one aims to conduct an action such as an invitation in a specific turn (see Drew, 2005, p.82-86).

Social action: This is concerned with a mutual understanding which people must have in order to successfully enact conversation. Drew (2005, p.86-89) elaborates that people perform social actions in their turns at talk, and people construct their turn to perform an action or to be part of the management of some activities. In CA research, we underline how people recognise or understand the other's conduct. For example, in HIV counselling we analyse how the nurse recognises the sensitivity of the topic of death. The nurse can understand that this topic is sensitive if she sees the patient's awareness of dying demonstrated by their action of crying, and the nurse can then show her orientation to such sensitivity by touching the patient. This indicates that the nurse understands the patient's conduct through the action of crying. This means that both the nurse and patient have a common sense knowledge which can be referred to in conversations.

Sequence organisation: Heritage (1997, p.161-182) states that 'it is by means of specific actions that are organised in sequences that participants initiate, develop and conclude the business they have together, and generally manage their encounters'. Adjacency pairs are the most basic form of sequence organisation (see Drew, 1994 and 2005, and Levinson, 1983). For example, we may address sexuality in HIV counselling. This topic has typically been managed through the use of questions and answers. In looking at sequence organisation, we can show how the nurse and patient initiate, develop and conclude the talk about sexuality. The sequential opportunities and constraints are shown in how the nurse talks to the patient and how the nurse is oriented to the roles and tasks of the setting. This may result in interaction with symmetry or asymmetry.

Repair: Repair is a mechanism for resolving problems or troubles of understanding, speaking or hearing in conversations (see Schegloff, Jefferson and Sacks, 1977). Drew (2005, p.96) points out that self-repair is also a mechanism for remedying mistakes in conversation where a speaker makes attempts to design

his talk to convey precisely what they mean to say. Repair is also used in circumstances where what a speaker claimed is in error. For example, the nurse uses a repair to clarify to a patient what she means in terms of safe sex (see Chapter Seven).

3.5.2 CA and ethnographic method

Combining CA with ethnography was effective in some medical interaction studies (see Heath, 1986; Peräkylä, 1995; Silverman, 1997, and Chatwin, 2003).⁴⁴ In other areas such as courtroom interaction between a lawyer and client, Halldorsdottir (2006) also combined ethnography and CA.⁴⁵

Ethnographic methods: As shown in a previous chapter, I used ethnography⁴⁶ to understand the complexity of the AIDS phenomena. Bourgois (1996, p.13) stresses the importance of ethnography by stating:

'Ethnographers usually live in the communities they study, and they establish long-term, organic relationships with the people they write about. In other words, in order to collect 'accurate data', ethnographers violate the canons of positivist research; we become intimately involved with the people we study' (Bourgois, 1996, p.13).

I spent several months in the research site and I learnt about the AIDS phenomenon by talking to nurses, medical staff and patients. Participating in the community also allowed me to understand how AIDS treatment and holistic care were provided.

The ethnographic data were striking, but they were not integrated in the core data analysis. Burnard and Naiyapatana (2004, p.227) point that 'it is not usual for Thai people to talk about their thoughts and feelings very openly or publicly'. Burnard and Naiyapatana (ibid) also state the characteristics of Thai people in that they seem not to make others feel uncomfortable. This thus may

⁴⁴ Heath (1986) combined ethnographic methods and CA in medical interaction. Peräkylä (1995) demonstrated this in his work on AIDS counselling. Silverman (1997) also conducted analysis of HIV counselling by combining these two methods. Chatwin (2003) applied ethnographic study with CA on communication in homoeopathic therapeutic encounters.

⁴⁵ See Halldorsdottir (2006) on the client's instructions: lawyer-client interaction and criminal defence case preparation.

⁴⁶ See Atkinson et al., (2001) and Bryman (2001).

influence the way in which they answer during an in-depth interview. In other words, they are oriented to normative standards. In addition, Burnard and Naiyapatana (2004, p. 228), in the same work, argued that key informants may not answer what the researcher really needed as illustrated in the following statement.

'There were occasions when the interviewers were in doubt that they got beyond the superficial, 'organisation-positive' views. Some informants were keen to present themselves as 'modern' Thais, to a degree that sometimes sounded exaggerated. Others were keen to stress how 'good' nurses were and their accounts seemed uncritical'
(Burnard and Naiyapatana, 2004, p.228).

This information probably seems to be a reminder for any ethnographer, especially when we need natural data on sensitive topics such as sexual conduct and death. For this study, I did not set ethnographic data and information to play much of a role in the recording and analysis of consultations, but at the same time I did not deem that the ethnographic data were not significant. The ethnographic data may not tell or give me what the nurse and patient actually did. But they help me understand the picture of HIV/AIDS. CA can give me what the nurse and patient actually did, for example how they manage the issue of sexual conduct. I thus applied the CA approach to analyse data from counselling sessions.

CA approach is used to analyse conversation between a nurse and patient. Although CA traditionally focuses on turn-taking, I do not apply CA to look at the specific practices of turn-taking in conversation in my study. Instead I use the sensibility of CA to look at the dynamics of interaction more broadly. I investigate how things and actions have been achieved.

My study does not aim to investigate in fine detail the practices for opening and closing a topic. I am interested in the matter of topic initiation. I then focus on how the topics are initiated and how the nurses introduce the awkwardness and the delicacy of the topic such as sexuality and death. I wish to analyse what the nurse uses to introduce the topic and what they are doing with that topic. I apply CA to uncover what actions and methods the nurse uses to open and close the topic. I do not aim to study the use of figurative expressions for topic transition and termination sequences or the practices of closing the topic

down and opening another (see Drew and Holt, 1998).

In addition, I look at what kinds of topic the nurse and patient talked about, how they came to discuss them. In particular, I establish the picture of who initiates those topics. This is one aspect related to the CA approach which I wish to apply.

The actions I undertook to understand the aspects outlined above were to record the data and transcribe it in detail. The recordings and transcripts are the object of analysis. The data extracts are used to illustrate the main patterns found in consultations, for example that the nurse tends to initiate a certain topic. Thus my transcripts are slightly more ethnographic. The video recording shows the use of some body movements that are found in interaction such as touching, stroking or caressing, though these were not transcribed systematically. Video recording covers not only verbal communication, but also non-verbal communication, actions and behaviours. By looking at a video, I have access to the specific context in which the nurse and patient are sitting and interacting. The data on the video can help me check any ambiguity. For example, when a patient takes a long pause, it may include that they are thinking or instead they may be stressed. By utilising the video recording, I may be able to resolve and control such ambiguity. In addition, video can verify the sense of emotion. Patients expressed their feelings and emotions through behaviour such as gaze, touching, stroking or pointing. However these do not play an important part in data analysis, though they are sometimes relevant.

3.5.3 Application of CA to HIV/AIDS counselling

I apply CA to reveal the overall structure of Thai HIV/AIDS counselling. My study also aims to use CA to explore how delicate topics such as sexuality and death are conducted in such a structure, in a similar way to Silverman and Peräkylä (1990), who applied CA to study the interactional organisation of talk about delicate issues in an English clinic.⁴⁷ Specifically, I investigate how those topics are initiated, whether directly or indirectly. I wish to include what kinds of

⁴⁷ The analysis of advice-giving in counselling shows that the counsellors switched the topic and they did not proceed with whatever concerned the patients as their own account for their behaviour. Indeed, the counsellors returned to delicate issue of sexual behaviour in the context of the delivery of information.

questions or statements counsellors and patients use in their turns. In addition, CA helps explore the delicacy and awkwardness of a topic as Haakana (2001) showed in the context of doctor-patient interaction. He showed that at delicate points in consultation if the patient laughs, the doctor does not laugh in case it is interpreted that the doctor is laughing at the patient. However my study does not focus on laughter, but I rather focus on topic initiation. I apply CA to study how the nurses deal with and obtain information from patients on awkward topics such as sexual conduct. For example, I look at how the nurse uses different questions to ascertain whether the sexual partner of a patient left his penis in her vagina after he reached a climax. My study also addresses the issue of death and how the delicacy of that topic is handled.⁴⁸

CA helps reveal how some particular aspects in interaction such as advice-giving were conducted. My study does not aim to investigate this in as fine detail as that of Heritage and Sefi (1992). I am interested in how the nurse conducted the process and what kinds of advice the counsellor gives and how the nurse continues such advice-giving.

In summary, I apply CA to study actions and activities which nurses and patients have conducted in conversations. I do not focus on the practices of turn-taking. I could apply CA to counselling because there are some special characteristics of CA that make it suited to analysing this type of data.

3.5.4 CA and other qualitative methods

CA is different from other methods like in-depth interviews, focus groups or questionnaires.⁴⁹ In these forms of data collection, participants are asked questions. For example, in the context of counselling, nurses have been asked what they have done in sessions, how they feel about their work, what they intend to do in counselling, how they handle particular topics or whether they found their work difficult. In other words, they have been asked about their practices.

⁴⁸ Techniques used to handle the delicate topic of death in Thai conversation and the stages of talking about death and dying were presented during the International Conference on Conversation Analysis, 10-14 May 2006, Helsinki, Finland. Constructive comments were given to complete this aspect.

⁴⁹ Positivism, grounded theory, discourse analysis (DA), content analysis and ethnography are the main quantitative and qualitative methodologies in Thai social research.

For CA, I recorded consultations in order to look at what nurses have actually done in counselling. I did not want to know what they intended to do or should have done. Silverman (2000, p.91-92) states the importance of naturally occurring data in the HIV counselling he experienced in that he did not attempt to interview the patient because he focused upon what the doctors and patients actually did rather than upon what they thought about what they did. It is not necessary to assume that when people are asked about thoughts and intentions, they do not tell the truth. Irrespective of this, data obtained by these other qualitative methods may be inaccurate in these two respects.

First, in interview and some forms of questionnaire, participants may try to provide answers that the researcher expects to or wants to hear. In this regard, Kitzinger (2006, p.155) illustrates this by stating:

'The problem, for researchers, with interview talk as 'second-hand' data is that what people say in interviews may not accurately reflect the reality of their lives. People may deliberately lie or exaggerate, they may forget information that the researcher thinks important or they may try to give the sorts of answer they think the person asking the question wants to hear' (Kitzinger, 2006, p.155).

The way in which the people report how they should behave, live or eat showed that people recognise the normative standard. The information and answers given in the result of some studies reflect normative orientation. They may not objectively tell what they have actually done. For example, when I talked to some patients, they convinced me that they were aware of safe sex and used a condom. However, the interactional data show that some of them ignore advice about safe sex when they were in a particular context or circumstance. This example is a reminder that patients answer in ways that they suppose I want to hear.

Second, behaviour is contextually bound. People say particular things or perform particular actions only in specific circumstances. In a different context they would use another action or say something differently. How people behave depends on the particular context in which they have to make a decision. They are balancing the kind of interactional contingencies which arise from the context. For example, in my data, there were homosexual patients. One was rather candid. But another one was reserved. Their personalities were different.

When these patients were confronted with talking about sexuality and sexual conduct, there were certain interactional contingencies. Patients responded to that fairly similarly regarding their sexual conduct.

In interview data a nurse told me that she prepares most patients for death and the future, and she has to initiate the topic. I could see from the video recording how the nurse initiated it by using different techniques, such as referring to the course of infection, a third person or using a pause and some non-verbal communication. These would not be seen in interview data. In addition, nurses told me that they gave patients advice to have safe sex and use proper protection. Indeed I believed that they had done so. However, such interview data could not be used to support this belief. But when I had watched naturally occurring data on a video, I saw and heard how nurses gave patients advice. The data were more detailed. These aspects are thus important for the training of counsellors. It would be greatly helpful in the sense that it could be used to show nurses how they could give patients advice, and what kind of interactional difficulties they may encounter in giving that advice.

In focus groups we try to get people to think about a specific context. In general, for instance when we buy products, we have to look at the quality of products. But when we really come to a situation and face it, how people really behave in a specific context should be investigated.

Data from one-to-one interviews and most focus groups do not provide evidence about how people actually behave, only how they think they should behave. This means that people still construct or make up a context rather than seeing how people behave in a context. In contrast the type of data used in CA can show how people act in a specific context.

In summary, these two accounts are the main reasons why I would like to know how nurses and patients actually behave. I recorded their conversation in order to know what they have actually done, not how they say they behave. The data were given in recording and transcripts. These gave me a sense of how people adjust behaviour to the particular sequences or interactional context in which they found themselves. Next, I show specifically how the counselling sessions are processed into CA data and I illustrate the way I present the findings with excerpts designed for completing this study.

Transcript: Producing a transcript of the video recording was a difficult,

time-consuming but necessary process. In the transcription, I have followed the conversational analytic conventions developed by Jefferson (see Jefferson, 1984a), but a slightly less systematic and developed version than that she recommends (see Appendix A). The nurse and patient talked in a dialect found in the north of Thailand, which is not used in Bangkok where I live. To deal with this, I asked for assistance from the nurses to help with the transcription.⁵⁰ All of the transcripts were checked several times: in particular I repeatedly listened to all utterances produced in each session, and I asked nurses to clarify those items I was not clear about.

Translation: Another problem was found in translating the Thai transcripts into English. Apart from being a time-consuming task, translation leads to difficulties. There are many different aspects between Thai and English. The first difference is the word order. For example, the way in which adjectives are used in Thai is different as they are placed after the noun. In contrast, in English, adjectives are always put before a noun. One will say 'dying patient' in English, but in the Thai context, people would say 'patient dying'. This is a simple example of a difficulty in translation. The way the word order differs between English and Thai affects the placement of linguistic symbols. However, I made an attempt to make transcripts clear to native English speakers and non-native speakers with English as a second language. The translations are not always accurate English.

Moerman (1988, p.39) noted that in Thai conversations, Thai people use particles for interactional tasks. The use of particles in northern Thai language is different from that in central Bangkok. In translation, the word 'right' was used to indicate a particle. Throughout this study, the use of particles conveys polite agreement by the patient. Sometimes, it was used by the nurse to make a particular utterance into a question. The nurse always used particles to stress the particular issues to which she wished the patient to respond.

Analysis of phenomena: There is no specific technique for an analysis of interactional phenomena. 'In fact, conversation analysts employ a wide range of essentially interpretative skills in their research' (Hutchby and Wooffitt 1998,

⁵⁰ As shown in Chapter Two, nurses helped me transcribe counselling cases because I had difficulties in understanding the local language. This help greatly reflected one of the nurses' willingness to be involved with my study.

p.94). Thus, the analysis of phenomena depends on the researcher. Schenkein (1978, p.6) analysed the techniques in stages and described it as 'the conversation analytic mentality'. Hutchby and Wooffitt (op.cit.) state that '[t]he conversation analytic mentality involves more a cast of mind, or a way of seeing, than a static and prescriptive set of instructions which analysts bring to bear on the data' (op.cit., p.94). However, at this point, I should illustrate in brief how I analysed the data.

First, my supervisors and I started by looking at video counselling sessions alongside an English transcript. Important themes were then categorised, and each theme was explored in depth.

Second, each theme was analysed in turn, starting from the first case. The interactional phenomena were found at this stage. It is important to note that from my direct experience, an interactional phenomenon is discovered after repeatedly listening to a case and by re-viewing a video. Psathas (1990, p.5) points out the interactional phenomena by stating that '[t]he phenomena are the 'stuff', the minutiae, the details of everyday activities as these actually occur in the world of everyday life'. I then explored other deviant cases, which contained the same themes (see the exploration of case no. 35 in which the patient was holding a monkhood. This patient was of a higher status than a counsellor. He reserved an active role. The nurse applied a different communicative style to address him).

Last, the same processes and techniques were applied to each theme in turn until all themes were covered.

Data presentation: In presenting data in the next four data analysis chapters, I show excerpts along with descriptive analysis. It is necessary to show excerpts from counselling sessions throughout the data analysis for a number of reasons.

First, the illustration of sequences of talk through transcripts is done in order to demonstrate validity. In CA, it is important to verify and ground one's observation clearly and fairly in the data and in the details of talk between the patient and counsellor to the natural data. Although this study is based on field work and data collected in Thailand, supervisors can understand the translation and meaning in the context of English. This is because CA transcripts include body language such facial expression, gaze and gestures. In addition, some utterances are similar to English in their sounds, and pitches. Non-Thai speakers

can also follow transcripts because co-participants clearly pronounced some prefaces such as ‘uh’ ‘um’ ‘orr’ and ‘ah’.

Second, an excerpt must be shown in order to illustrate and verify the interpretation made by the researcher. In this study, I analyse and present data as follows.

First, I will briefly address what I am going to talk about. I then show the relevant excerpt with linguistic symbols. I then analyse the data using lengthy description. The linguistic symbols used are shown in detail in Appendix A.

Second, in each excerpt I allocate the number of the excerpt as follows: the first number indicates chapter, followed by the number indicating the number of excerpts in that chapter. Second, in parentheses, I illustrate the case number, for example 01 or 43. Following this, I demonstrate the precise location of the data by indicating the number of minutes into the consultation where the excerpt took place, for example 22:35. Last, in another parenthesis, the source of data will be demonstrated; whether it comes from audio or video recording. This is presented every time a new case is introduced to the analysis. This description is not presented in the next excerpt if it is from the same case as the prior excerpt, and such excerpts are presented continuously without being interrupted by excerpts from other cases.

3.6 Conclusion

The data collection was conducted in accordance with ethical standards. Ethnographic methods such as interviews, focus group and direct observation were used to supplement data collection. The data in interaction, based on naturally occurring talk, was the core data to be analysed. Data from other sources did not affect the core data and techniques for analysing data. In addition, I chose to study themes I wished to highlight, not those that counsellors wished to highlight. My study was not aimed at looking at the practices of turn-taking and sequential analysis, thus it was more ethnographically informed. I used a naturalistic methodology which can uncover the way in which the nurse and patient interact and how their actions and activities were conducted. CA thus fits

such an intention. CA is applied to explore how actions and activities in HIV/AIDS counselling are conducted.

In the next chapter, I will show what the counselling in the research site was like; the chapter is concerned with the important reflection of ethnographic and interactional data in real counselling phenomena. In other words, I illustrate the macro and micro level of counselling.

Chapter Four

Counselling in Practice

In the previous chapter, I illustrated what I had observed and conducted in the research site. This chapter aims to give ethnographic findings and some preliminaries about the interactional data; it presents an overview of HIV/AIDS counselling. I underline three main aspects. First, I outline the health care system in Thailand at the macro level. In this section, I also explain how HIV/AIDS counselling is one of the missions of the Ministry of Public Health. Second, this chapter shows the local context of counselling. Third, I move from the local context to the micro level by describing the HIV/AIDS counselling home care package in the field research site. At this point, the structure of HIV counselling in this largely rural mountainous area is shown. The factors that shape the counselling are illustrated.

4.1 The health care system: macro level

Burnard and Naiyapatana (2004, p.48) state that ‘Thailand has an extensive network of public health facilities down to at least the district level, and an expansion of medical education has increased the number of doctors’. The Ministry of Public Health in Thailand has decentralized decision-making, authority and management to the community level. Community hospitals are responsible for health care, including the alleviation of HIV/AIDS. Health care in Thailand is run in co-operation with international organisations such as WHO, UNAIDS or the EU (see WHO, 2004). As shown in Chapter One, the Thai government has utilized strong co-operation with worldwide organisations such as WHO. This results in AIDS care incorporating guidelines for HIV/AIDS counselling that originated in western cultures. In the Thai context, HIV/AIDS counselling remains flexible in a socio-cultural context. Theory originating from western countries is integrated with cultural aspects from the Thai context. For

example, religion is an important ingredient that is brought into discussions about death and dying and forgiveness for stopping the spread of infection. In this area, Burnard and Naiyapatana (op.cit.) points out that Thai culture has shaped the nursing in Thailand. For example, hierarchy and religion in Thai social structure influence the Thai nursing system. They noted from ethnographic data that the older patients were treated respectfully. This reflected in the way in which the nurse chose terms of address such as aunt or uncle to address those patients. Buddhism appeared to have an important influence on many aspects of nursing. Buddhism is used to encourage patients to regard death and dying as a cycle of life.

The Ministry of Public Health provided nurses basically with the public health role. The health care system thus provided included home and community visits. The nurses visit people in the community in order to assess and evaluate the health services. They have to ensure that people understand and make use of health services properly. In addition, '[t]he nurses work with communities or specific population groups within the community to develop public policy and targeted health promotion and disease prevention activities' (Shovein, 2003). Medical staff may visit people in villages more often in case the spread of some contagious disease is severe. In rural areas, home visits become more vital because people live in different cultural contexts. For example, people in hill tribes speak a different language. The way in which they eat is different. Medical staff may make use of interpreters. Medical staff have to make sure that people in their village understand what they are told properly.

We have seen that the Thai health care system is run in co-operation with other organisations. The nurses were oriented originally to public health. They thus integrated their nursing knowledge with community visits. Each community may differ in cultural context. The culture thus shapes the way in which Thai people and patients live, eat, speak and behave. The home visits are needed. The cultural context in Thailand plays a part in shaping the nursing system and the way in which the communication in nursing is used. This also results in HIV/AIDS counselling.

4.2 The local context of counselling

In Thailand, the government established confidential or anonymous HIV voluntary counselling and testing (VCT) in all provinces in 1992 (see Kawichai, et al., 2004). HIV/AIDS counselling can be conducted by medical staff, health workers, NGO officers, psychologists, or religious people. In my study, the counsellors were nurses, a midwife, a psychologist and one health educator. They were concerned with the public health role. However, they were trained on a HIV/AIDS counselling course, on at least one basic course.

Patient-centeredness strongly underpins theoretical knowledge on Thai HIV counselling, and this has been prominent in counselling sessions. It is important here to be clear what is meant by 'patient-centeredness'. Rohleder and Swartz (2005, p.399) state that '[t]he client-centred approach emphasizes the centrality of the counsellor-counsee relationship and aims to develop counsellors who respect the position of those they counsel without imposing their own values'. Seale (1998, p. 99) states that '[p]atient-centeredness, then, is a broad movement in health care, drawing on the psi-science to represent a new interest in patient subjectivity and refiguring relationships in the caring team'. In order to apply this ideology, nurses as counsellors have to encourage their patients to talk about what concerns or worries them. Koetsawang (1999), who got involved with HIV counselling during the critical stage of the epidemic, remarks on this from his direct experience. He claims that patient-centeredness is an important theoretical framework for HIV counselling in Thailand. Details provided by Koetsawang show that any problems should be resolved by the patients themselves. He further emphasizes that counsellors should be involving and assisting their patients as facilitators of the discussion. Counsellors should not exploit their own ideas overwhelmingly (ibid, p. 54), and nurses are expected to be more passive. In other words, patient-centeredness underlines the attentive listening skills of counsellors. The counsellors have an obligation to apply their listening skills in sessions. Of course, in the context of patient-centred counselling, nurses also expect topics to be initiated by patients.

The health care system provided by the government is not completely separate from the community; it is part of the public health role. People, patients

and medical staff interact socially and this shapes how the health care system is provided. One simple example is provided by the way in which medical staff contact and communicate with their patients. They may ask for help from neighbours or relatives to take messages to patients in remote areas. Another example relates to the fact that AIDS care and treatment must be provided with respect to high patient confidentiality. Without proper care a patient's infection may be inadvertently revealed.⁵² In the Thai context, on some occasions, the community and family are included in AIDS care.

One of the important missions of the hospitals is to provide HIV/AIDS counselling. The counselling is routine and is conducted with quite limited resources as is typical of most services provided by community hospitals. Patients might sometimes be referred to other more well-equipped hospitals. However, medical staff have a concept that a patient should not die in their hospitals.⁵³ Consequently, counselling nurses have to work hard at their jobs. It is true that the number of HIV/AIDS patients puts a strain on some hospitals. Counselling is important in this respect because it plays a part in the control of infection and monitoring sexual conduct and the cause of infection. In addition, counselling encourages patients to cope with any problems emerging from infection.

AIDS care is not only performed in medical settings; the home care system also plays an important part. Consequently home visits are conducted with the permission of patients. Patients have full rights to have their confidentiality and disclosure protected. Visiting patients at homes allows nurses to find out about their life styles, sexual conduct, discrimination, family business and any worries which might affect their health. These home visits seem to be different in the Thai context in comparison to those in western countries. Every time, prior to any visits, the nurse would visit her patient and family carefully. The nurse would ask for permission from the patient and relatives. This is because in the past discrimination towards the patient had emerged following the nurse's visit. Some patients were not open with neighbours. The way in which the nurse dresses helps

⁵² In some counselling cases patients asked for counsellors to design messages in a particular way in order to hide their infection.

⁵³ I understood this concept more from reading on a Thai website on community hospitals. One subtitle can be translated into English 'a patient cannot die in a community hospital, that will make trouble'. In the original the Thai is ' คนไข้ตายในรพ.ไม่ได้นะ เค็ดวามีเรื่อง' (see Anon).

hide the patient's infection. The nurse did not wear a uniform. She prefers motorcycling to using a hospital car or van. Neighbours might suspect if a hospital car is parked in the village.

When people were diagnosed as HIV positive, they were informed about treatment with ARVs. This is included in most counselling sessions. Counsellors introduce ARVs to patients. During the period of data collection, a programme of ARV had just been launched by the Ministry of Public Health. Consequently, a trial was organised and some patients who met the inclusion criteria were screened to participate in the programme.⁵⁴ The patients needed to be followed up to monitor any symptoms from taking these ARVs. The experiment was designed to explore the subject of sufficient efficiency and whether these ARVs work properly.

As well as providing medical treatment, medical staff might get involved with the HIV patient network. This is also part of the public health role; the nurse worked with a specific population in the community. They assist patients in co-operating with other networks and initiating income-generating activities. Patients are encouraged to participate in the HIV patient network group so that they have someone who is in the same circumstances to listen to them. They can also act as a source of information for each other: some may have information on careers and employments. Patients also come to the network for emotional management.

In summary, I have shown the local context of counselling. The counselling was an important mission in the Thai health care system. The counselling nurses applied the public health role and the knowledge from counselling training into the counselling task. Home visits were thus included in Thai counselling.

In the next section I discuss the counselling at the micro level. The data underpinning this picture were from natural data in the counselling sessions.

⁵⁴ This programme is now available across the country. Patients could get equal access to ARVs.

4.3 Thai counselling: micro level

Numerous works on AIDS counselling have been concerned with the implications of being tested and receiving a positive test result. HIV/AIDS counselling in Thailand is in part concerned with people living with AIDS, and forms part of the home care package for the people infected with AIDS. The counselling is thus aimed at helping patients know how to live and behave.

The data show that patients come to see a counsellor with different purposes in mind. In the examples collected during field research, most of the patients came to see the nurse more than once, and thus the meeting recorded for the research was not their initial meeting. Many patients seek treatment, and some patients come to talk about something other than health issues. Most sessions (39 cases) were conducted with a single patient, but couples (3 cases) also came to talk to the counsellor together, and some patients were brother and sister (1 case). The nurse tackled the problems of each patient in turn. Usually, the nurse talked to a few patients each day—some in the morning and some in the afternoon, not including emergency cases. If an emergency arose, the nurse would see more patients than planned if it was necessary. For example, the nurse might talk to a patient who was really worried, so much so that he or she might be regarded as potentially suicidal. At day care in some settings, the nurses talked to more patients than in routine practice in order to follow up on treatment. Day care took place weekly.

Although some nurses voluntarily did counselling work, talking to several patients one after the other may lead counsellors to burnout. One of the characteristics of burnout amongst counselling nurses is 'loss of motivation' (see Burnard, 1991, p.8). The way in which most counsellors cope with the emotion, stress and burnout emerging from counselling is to talk to other people. Nurses as counsellors also need a counsellor. Counsellors always talk with their husbands. Ethnographic data showed that the husbands of the nurses had an understanding of their wives' routine work, and they also comprehended how this might lead their wives to become stressed. As a result, they revealed that the encouragement and emotional support given by them were necessary and valuable in their wives' work. They confessed that their support could decrease the 'burnout' rate of the

nurses. Some counsellors talked to their colleagues who were also counsellors. At least they all were in the same situation (ibid, p.13).

In each session, the patient was categorized. The nurse classified the patient into different groups based on the stage of infection, the gender of the patient and the sexual preference of the patient. In addition, the patient was classified by marital status, and by other specific details such as whether they were a drug user. This categorisation determined the conduct of the counselling and the nurse's behaviour towards the patient in counselling. For example, the categorisation by the nurse determines her use of non-verbal communication. When the nurse talked to a male homosexual patient, she often touched the patient, but she would touch a female patient more often and would rarely touch a male heterosexual patient. The category of patient becomes significant for conduct in the counselling itself.

When the nurse talked to patient, the nurse tried to find what issues that concerned them. Some patients wished to be treated with ARVs. ARVs were available under a programme launched by the Thai government, and some patients were selected to participate in the experimental programme of ARVs. Some patients were encouraged to participate in the programme, which leads to screening and non-screening interaction. Patients on the programme of antiretroviral drug use are screened. Non-screening interaction is for those seeking treatment.

4.3.1 The structure of counselling

In each session, the counselling is opened, developed or discussed and then closed. This seems to be a universal structure of health consultation. In Thai health consultation, the conversation was typically opened by a formal greeting, conducted by using a verbal utterance such as '*sawatdee*' and/ or gestures such as the putting together the palms of the hand (the so called '*wai*'). However, in some cases the nurse may not employ a greeting. The nurse may open the conversation by other means such as referring to the last meeting. In terms of greeting by words or gestures, in the Thai context, sometimes, the nurse and patient met outside the counselling room. Thus, a greeting might have been conducted when the patient first arrived at the medical setting, and we thus did not see any

greeting in the recorded session.

After having been opened, the conversation was then developed under a system of turn-taking in conversation. At this stage, I refer to it as 'in between' in the structure of counselling. The data show that there were a number of themes raised for discussion and resolution in most sessions; such as health care, emotions, the prospect of death, antiretroviral drugs, family and community, financial circumstances, HIV patients network, confidentiality and disclosure and sexuality. However, some themes might not be present in some sessions. Consultation at this point is thus not limited or confined to one topic such as health care. The nurse and the patient discussed different inter-linked topics. The conversation between the nurse and patient is generally initiated by the topic of health care, but it moves around to include other themes. The conversation is therefore not always terminated on the topic of health care; it may be ended by something else or on another theme. It may be clearer here if a diagram is drawn to show how these topics are cycled. The following Diagram no 4. shows the cycle of topical areas raised in HIV/AIDS counselling.⁵⁵

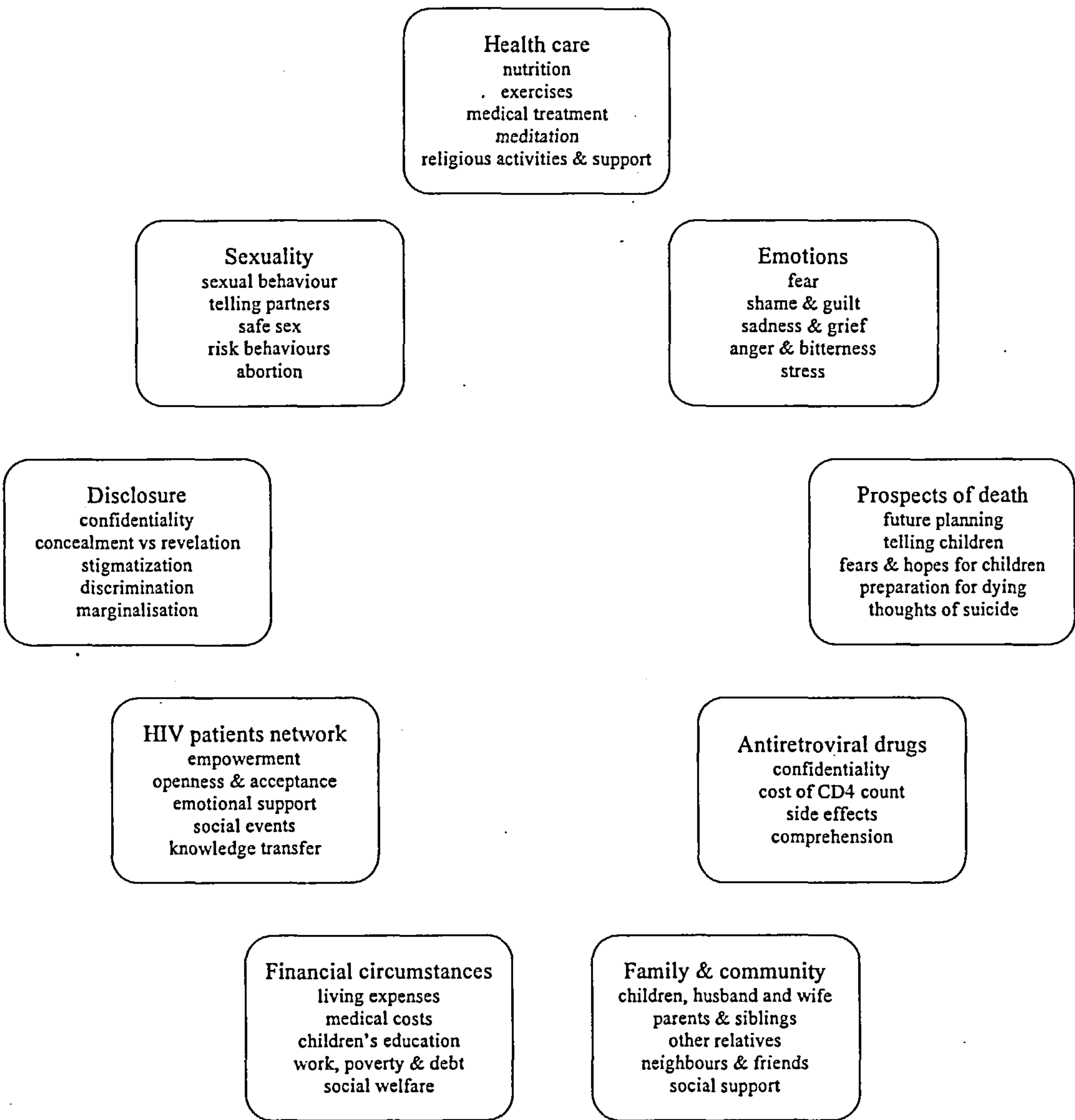
In between the opening and closing of conversation, in order to address several topics, the nurses sometimes change the topic rather abruptly, and this behaviour is observed in my data. Such movement between topics allows the nurse to probe further in many areas. When the nurse starts another topic, sometimes she may not follow it up. It seems that the nurse applies a checklist in health care consultation, and thus tries to cover standard topics, as mentioned earlier. This is worth doing while the patient is there. The way in which the nurse directed the conversations was by discussing what concerns the patient. The nurse then continued to other topics. However, the nurse may sometimes come back to the same topic such as the topic of health care. This seems to be different from counselling in a western context, where health consultation is terminated rather formally before the co-participants move into another context of talk. In other words, the participants did not tend to come back to discuss a former topic.

In addition, some topics are deliberately addressed more than once. This is not because they are important, but it is simply because the nurse has not

⁵⁵ Topical areas cycled in HIV counselling depicted in Diagram 4 were presented in Poster no. MoPeE4106 during the XV International AIDS Conference, which was held during 10-14 July 2004, Bangkok, Thailand.

ascertained what her patient wants or whether the patient is able to solve the problem. The nurse decides to come back another time or reformulate some topics to make sure that the patient understands the messages well, and to know whether the patient is clear about the resolution.

Diagram 4. Topical areas cycled in HIV/AIDS counselling



All topics are interconnected with each other. The topical areas that were covered seem to form a checklist for the nurse. The nurse introduces the topic of health care, and then moves onto the prospect of death. She then moves further into health care another time. I should show how this conduct has taken place. In one case, the patient was worried about painful symptoms. She showed her worries

through facial expressions and the nurse was able to tell that she was worried about cancer without having to ask a direct question. At this stage the nurse wished to make the patient less worried about the possibility of getting cancer. In her explanation, the nurse referred to another patient who died of cancer. Then both of them continued discussing the prospect of death. It is clear that the context of conversation was renewed smoothly without terminating the first topic.

In the micro analysis, the sessions showed that the structure of Thai counselling was cyclical, which differs from the linear pattern found in general health consultations in the western countries.

Transformation of context in health talk depends on the nurse's skill in picking up on clues from the patient. This represents to some extent the practicality of HIV/AIDS counselling. In addition, another crucial aspect in this counselling is that the nurse often makes a conclusion and gives a summary of what she and the patient have discussed. This is because the nurse wishes to clarify the issues that concerned her patient.

In closing a conversation, as stated earlier, the closing is universal. However, in Thai counselling, the topic at this phase was not always the same topic that was used for opening the conversation. In other words, the conversation might be closed on other topics. The nurse always closed the conversation. The way in which the conversation was closed was that the nurse normally asked what else the patient would like to discuss and when to see each other again in the future. In addition, the nurse blessed the patient for being healthy. Specifically, in a non-screening interaction, the nurse might close the interaction by recommending that the patient decide whether to use ARVs. At the end of the conversation, the nurse and patient typically produced verbal utterances such as '*sawatdee*' and/ or a cultural gesture such as '*wai*'.

Having provided a description of the scene and structure of counselling, I show a table of the structure of counselling, for both screening and non-screening interaction. Screening interaction is the counselling in which the nurse tried to encourage her patient to participate in the ARV programme. There are 18 cases which the patients were not on the ARV programme. Patients were encouraged to take ARVs, but they had to have their blood tested to count CD4. Non-screening interaction is the counselling in which the nurse did not encourage the patient to take ARVs. This is because some patients might have already taken those drugs.

Some patients might not need to participate in the programme as their CD4 was still higher than 200.

The following table (Table 1) illustrates the structure of Thai counselling. The phases or stages are universal in terms of opening, evolves and closing. However, in between the opening and closing, the conversation is evolved by different topics and it might be terminated in other contexts.

Table 1. The structure of Thai counselling

Screening interaction	Non-screening interaction
<i>Opening conversation</i> Greeting by word 'sawatdee' and/ or gesture 'wai' or other talk followed by health care	<i>Opening conversation</i> Greeting by word 'sawatdee' and or gesture 'wai' or other talk followed by health care
<i>Evolving by Discussion of different topics;</i> Other topics Emotion The prospect of death Antiretroviral drugs Screening on the use of ARVs Family & community Financial circumstances HIV patients network Confidentiality & disclosure Sexuality	<i>Evolving by Discussion of different topics;</i> Other topics Emotion The prospect of death Antiretroviral drugs Encouragement for the use of ARVs Family & community Financial circumstances HIV patients network Confidentiality & disclosure Sexuality
<i>Closing conversation</i> Anything else Be healthy See you again Good bye by word 'sawatdee' and/ or gesture 'wai'	<i>Closing conversation</i> Anything else Make up your mind on ARVs Be healthy See you again Good bye by word 'sawatdee' and/ or gesture 'wai'

The table of the topical areas covered, the accompanying explanation and the table illustrating the structure of counselling lead this chapter to discuss further why the structure of health care and the topics therein appear as they do. Here, it is time to explain the particular characteristics of the relationship between Thai medical staff and patients. I should note that this relationship is different to that found in western cultures. It has a hierarchical nature. Nilchaikovit, Hill and Holland (1993) compared the physician-patient relationship between American and Thai cultures. They showed that in western cultures, such as in the American context, the relationship between physician and patient is an egalitarian one, based on a contractual agreement. That agreement was influenced by ideological aspects around individualism, autonomy and consumerism. Thus the relationship is consensual, not obligatory. The patient and physician should be willing to negotiate, and the participation of the patient is important. However, in Thai culture, the relationship between the doctor and patient is constructed in a hierarchical way. Thai social structure is hierarchical (see Burnard and Naiyapatana, 2004). This can be seen in the use of language and communication such as pronouns or a cultural greeting by bodily movement in Thai conversation. The young and the elderly have different status and have different pronouns used to indicate themselves. In Thai conversation, the nurse used a particular pronoun to indicate her older status with some younger patients. Iwasaki and Ingkaphirom Horie (2000) state that in Thai conversation, there are three formality level pronouns. They are high, mid and low formality level pronouns. The relationship is thus characterized by an emotional connectedness and interdependence with full expectations of reciprocity, and highly empathic sensitivity to one another's feelings and need without explicitly expressing them (ibid). This results in the use of non-verbal communication in medical interaction. This particular relationship leads to one characteristic of medical interaction, and that is that medical staff are trusted considerably and respected by the patient. In addition, in the Thai context, the aspiration in decision making seems not to exist. By contrast, in western cultures the patient has an aspiration in decision making in health care that is more obvious than in Thailand. It is quite clear that counselling has been shaped by a hierarchical relationship.

Another possible explanation may be given to account for the observed structure of counselling and topic changes. This study looks at the relationship

between a nurse and patient in the context of counselling in a rural area. The counselling has been conducted as if it were people in the same family talking to each other. In other words, counselling is shaped by the close ties between the nurse and patient, and this is different to the relationship found in western cultures. Medical staff may occasionally visit patients and their relatives at the patients' homes. This gives rise to the special characteristics of HIV/AIDS counselling in the Thai context, as the medical institution provides a home care service. In addition, in a Thai rural area, the nurse and patient are close to some extent. Most counsellors have prior knowledge of their patients' backgrounds. Thus, the nurses' understanding of those backgrounds influences the health consultation. For example, the nurse may pick up on the topic of the patient's children when she wished to encourage the patient to fight against death and hopelessness. With these characteristics of the Thai context, they help the nurse to move abruptly around topics as they see fit given their relationship and familiarity with the patient.

Another aspect which underpins the shape of health care consultation, is concerned with some issues in Thai social structure. The rural people who appear in my data are not well-educated. Thus, the way they see the nurse is rather different from that in western culture. The patients in a rural area may defer to the authority of the medical staff. This leads to them trusting their counsellors. At this point, it is important to note that the level of education and social structure shapes the relationship and conduct of counselling between the medical staff and patient.

At this stage, what I have drawn upon is closely related to the collected data. Consequently, I will now show an example to support the description of counselling in a Thai rural area. The whole transcript of this case is shown in Appendix D. The case shown represents an extreme session. It is clear that the session is nurse-centered, not patient-centered. The term 'nurse-centred' means that the conversation was directed by the nurse. The nurse engages the patient in talking, and is predominately the questioner. The nurse always initiated talking. The patient did not herself introduce a topic. The patient made statements in response to a question or statement from the nurse. This example is from case no.41. The counselling session lasted 38 minutes and 3 seconds. The patient had had the virus transmitted to her by her husband who died several years ago. She

is living with a daughter and her husband's parents. The patient categorised as a widow came to see the nurse because she was afraid of cancer. The conversation is opened by the nurse. In this case, the way in which the nurse opens the talk indicates that the nurse and patient have met before. The conversation is not initiated by a formal greeting such as *sawatdee* ('hello', 'good morning' or 'good afternoon' in English). Instead, the nurse asked the patient when she was discharged from hospital as shown on page 377 in lines 1-4. Then they discussed health care, as shown on page 377, in line 8 at 00:18 minutes, in particular symptoms, which were of considerable concern to the patient. Discussion of health care proceeded automatically and smoothly for both participants onto the topic of emotion at 02:23 minutes. They then discussed the health care on page 378, in line 82 at 02:35 minutes. After the discussion of death, the nurse reformulated the topic back to health care on page 379, in line 114 at 03:21 minutes. Next, the topic of ARVs was addressed on page 381, in line 216 at 06:53 minutes. They then moved to the prospect of death another time at 08:15 minutes, followed by the issue of family on page 382, in line 281 at 08:43 minutes. Here, it is important to show that the aspect of family is brought into discussion because the nurse knows the patient's background to some extent. After the issue of family, they discussed financial circumstances at 23:35 minutes. At this point, the nurse ascertained from the conversation that there were four issues which concerned the patient. They were painful symptoms, the patient's daughter, property and daily expenditure as shown on page 390, in line 757 at 23:48 minutes. These caused the patient considerable concern, and thus they were brought into discussion. After the nurse made a brief conclusion and summary about what really concerned her patient, she then moved to the topic of ARVs on page 391, in line 784 at 24:27 minutes. Then they moved on to talk about health care again on page 391, in line 803 at 25:04 minutes. After they discussed the health issue, they then moved onto family at 25:36 minutes, and followed by the issue of financial circumstances at 28:06 minutes. Then they talked about family at 30:59 minutes before they moved into lengthy sequences on the issue of HIV patients' network on page 395, line 1,045 at 32:37 minutes. At the end of the conversation, they discussed confidentiality and disclosure on page 397, in line 1,163 at 35:32 minutes. The patient told the nurse how she was discriminated against in the family. When talking about several topics, the nurse has to find a

way to make a conclusion as to what in particular causes the patient concern. Here it is clear that the nurse discussed what concerned the patient first. Then she moved onto what she had in mind as her checklist. The domination by the nurse, as evidenced above, renders the patient passive. It is important to show how the patient reserves himself or herself a passive role. The patient holds such status by rarely producing a question. This means that they rarely initiate a topic. Throughout the consultation, it is generally seen that the nurse always initiates the topics. In addition, the passive role of this patient can be seen through the turn allocation in conversation; it is often determined by the nurse. The turn size of the nurse and patient is also visibly different. In this counselling session the turn size of the Thai counsellor is greater than that produced by the patient, even though most patients were encouraged to talk.

The above example represents a case which is not completely typical because some aspects are not covered during the health consultation. It is important to supplement this example with some other cases to fully illustrate the scene of HIV counselling. Another case that can be referred to is case no.4. This male patient was categorized as a homosexual, and he came to talk to the nurse about seeking treatment with antiretroviral drugs. He required more information about the use of these drugs. During the health consultation in this case, many aspects can be found that were not included in the prior case. For example, the nurse and patient had taken it in turn to discuss the sexual behaviour of the patient. The nurse made an attempt to find out how the patient became infected. This topic is a matter of great significance for the nurse. At the beginning, the nurse did not seem to believe what she was told by the patient. This is because the nurse categorized this patient as a male homosexual, which was related to his feminine and sentimental appearance. His sexual behaviour must be expected to be different from other categories of patients. Thus, the nurse had to probe further. The nurse found out that in the past the patient rarely used condoms. The way in which the nurse discussed this topic with the patient was in a direct manner. For example, the nurse told the patient that he did not use condoms at all. In addition, the way in which the nurse touched the patient and tapped his hand and arm, was guided by the way the nurse categorized the patient. She touched the patient affectionately.

In talking about sexuality, the nurse takes a very strong line about what

the patient should do. For example, in another case, the nurse uses a forthright statement to directly tell a couple that they must use condoms. This couple is the patients in case no.7. The nurse uses 'must use condom' in her turn. This is direct and it leads the patient. Thus counselling in the context of sexuality appears similar to health education. The nurse typically makes an attempt to find out whether the patient has safe sex or not. It is clear that discussion of sexuality, and more precisely sexual behaviour, was not undertaken in the prior case because the patient was categorized as a widow and she did not have a sexual partner or sexual relationship. This is quite common conduct if the nurse found it unnecessary to probe into some areas with some patients.

There are also some interesting aspects found in atypical sessions in Thai counselling. Some patients are active in their sessions. The patients typically appear active if they need treatment. For example, the patient may ask for more information regarding the use of antiretroviral drugs, but this is rare. This is found in case no.13. The patient initiated the topic of antiretroviral drugs. She wished to prolong life, thus she brought the topic into discussion. In some cases, the patient is active and appears superior to the counsellor because the patient's social status (i.e. a monk) is high according to the Thai social structure. This is a special characteristic of case no.35, in which the patient was a monk. The high status of the patient is visible at the opening of the conversation through the use of bodily movement and verbal utterances. These are not aimed for use with people of the same status. The nurse employed '*wai*' and said '*namatsakarn*' to address the patient. Throughout the conversation, the nurse used a pronoun indicating her lower status, and the higher status of the patient. He was clearly active, and he asked for co-operation from his counsellor in hiding his infection for fear that he might be forced to leave his monkhood if his infection was revealed in the monastery in which he was living.

I have shown some cases from counselling sessions. The way in which the topics are conducted is different from health care consultations in western countries. Thai counselling was not conducted in a linear fashion, but in a cycle. In the next chapters, I will show health consultations covering most cases.

4.4 Conclusion

In this chapter, I have shown an overview of the health care system and HIV/AIDS counselling. The counsellors conducted counselling by applying the knowledge from counselling training. In addition, the counsellors' public health role also plays a part in counselling. The counsellors integrated the home and community visits. They visited the community and people in villages in order to make a surveillance of the epidemic. In addition, they conducted home care to ensure their patients understood what they discussed in counselling. The patients were followed up about taking ARVs and discrimination. The counsellors also worked with a specific population such as HIV patients network. In this chapter, I have described some health consultations emerging from my empirical data. It may seem odd to show that the structure of Thai health consultation in the context of HIV/AIDS counselling is different from that in the western context. In the Thai health care context, many topics were addressed, and were switched between one another as they appeared, while in the western context, the co-participants do not tend to move into another topic. They do not come back to prior topics. In addition, this chapter also shows a comparison of health consultation in the context of HIV/AIDS counselling in a Thai rural area to that in western cultures. The comparison makes the different characteristics visible. It is clear that what I have shown are important contrasts with what western cultures expect to know. Although the data show these differences, they do not affect the quality of counselling. The differences represent the real practice of HIV counselling in a Thai rural area, which has been conducted under western guidelines. Importantly, those differences are shaped on the basis of Thai cultural and social aspects, and this constitutes the practicality applied in HIV/AIDS counselling.

In the next chapters, I will pick up some important themes to show in detail how each is dealt with in consultation with the excerpts. They are the themes of joining and selecting for the programme on ARVs, disclosure and confidentiality, sexuality and the prospect of death.

Chapter Five

Joining and Selecting for the Programme on Antiretrovirals

5.1 Introduction

1. Nurse: there are places for 6 people
2. ((showing fingers))
3. Patient: ((nodding)) right (.) right
4. Nurse: there are quotas for 8 people
5. Patient: ((nodding)) right (.) right

The above excerpt is from a counselling session, and it is concerned with the use of antiretrovirals⁵⁶ or ARVs. It shows that although the patient wished to take ARVs, she must qualify for selection. ARVs are not offered to all patients who request them even though access to HIV/AIDS medicines has been strongly promoted. There are restricted numbers and ARVs have been allocated based on a quota. Patients who wish to take ARVs have to meet requirements. These make counsellors select appropriate patients to participate in the programme. Patients have to prove they deserve ARVs. The ARV programme in Thailand was initially launched as an experimental programme. Patients who participated in the programme were given ARVs free of charge. If this trial proves to be successful, the Government Pharmaceutical Organization (GPO) of Thailand has planned to manufacture for HIV treatment for all.

The introduction of highly active antiretroviral therapy (HAART) gives most patients hope, though HIV/AIDS is still incurable. The treatment is conducted using medicines. Oxfam International (2004) states that '[a]ccess to medicines makes a huge difference to the lives of infected people and their families'. In many cases, people living with HIV/AIDS have experienced that these medicines not only promote their longer lives, they also improve their quality of lives. Moatti and Spire (2000, p.59) state that '[t]hese new therapies can decrease viral loads to undetectable levels, and significantly reduce the

⁵⁶ Antiretrovirals or ARVs in brief are also called anti-HIV drugs and HIV antiviral drugs (see Hunter, 2005, p.226).

incidence of HIV-related opportunistic infections, and restore health and a decent quality of life among a large number of people with HIV and AIDS'. In addition, the introduction of antiretroviral therapy (ART) for HIV in 1996 'transformed the perception of HIV/AIDS from a plague-like disease into a chronic but manageable illness' (Hunter, 2005, p. 225 and see also Amico, Toro-Alfonso and Fisher, 2005). In this area, Tan (2005) also points out that '[i]n effect, the medicines have transformed HIV infection into a chronic disease like diabetes, with lifelong treatment'.

When the AIDS epidemic became severe, Thailand examined findings from an AZT⁵⁷ research study conducted in collaboration with the U.S. Centers for Disease Control and Prevention, and several AZT pilot implementation projects (Office of Public Affairs, U.S. Embassy in Thailand).⁵⁸ This led to action to curb the epidemic, and consequently Thailand became the first developing country which launched a national programme to prevent mother-to-child transmission in 2000, by using AZT with pregnant women. This is the first use to which ARVs were put in Thailand. Initially, AZT was not provided in the public health system. Some patients could afford it privately but it was still expensive.

Then the Government Pharmaceutical Organization (GPO) of Thailand produced others different courses for ARVs. Amongst these, GPO-Vir⁵⁹ seems to be outstanding. Oxfam International (2004) states that '[t]his simple and effective three-in-one tablet costs ten times less than patented versions of the same drugs made by Bristol-Myers Squibb (BMS), GlaxoSmithKline (GSK), and Boehringer Ingelheim (BI) respectively'. In order to alleviate HIV/AIDS, the Ministry of Public Health launched a programme of ARV use. Patients who participated in this programme are given these antiretrovirals free of charge. This programme was thus introduced in HIV/AIDS counselling sessions, and patients were persuaded to participate. Participation in this programme was dependent on the

⁵⁷ AZT or zidovudine is an anti HIV drug which has been adopted by governmental hospitals throughout the country for the national programme on mother-to-child transmission in Thailand.

⁵⁸ The sources of this information are from department of health and human services, centers for disease control and prevention. The report was compiled by Jordan W. Tappero, MD, MPH. This information was released by Office of Public Affairs, U.S. Embassy, Bangkok, October 20, 2003 (See Office of Public Affairs).

⁵⁹ GPO-Vir is the drug which is a combination of the anti-retroviral Nevirapine, Stavudine and Lamivudine. This anti-retroviral cocktail for treating HIV/AIDS was devised by the Government Pharmaceutical Organisation (GPO) (see Bhatiasavi, 2002).

conditions and criteria imposed by the Ministry of Public Health.⁶⁰

While initially the national public health system was not formally involved with the provision of ARVs, access to ARVs was then successfully pushed by concerned parties to be involved in the 30 baht medical care programme⁶¹ and other health and social welfare programmes. This means that Thailand is one of the countries which have begun to provide ARVs in the public health system. During the recent XV AIDS International Conference, 10-16 July 2004 in Bangkok, the Thai prime minister gave a speech at the opening ceremony of this conference under the theme 'Access for All'. The theme indicates that everybody should get access to AIDS information, and this includes access to ARVs. The prime minister stated that the Thai government has allocated more than 20 million US dollars for the project to cover most of the known cases, and the remaining 20% which would be supported by the Global Fund (UNAIDS, 2004b). This seems to provide evidence that Thailand has tried to make access to ARVs possible for all eligible patients.

However, there is some evidence that access to ARVs is still limited, and this is related to sociodemographic characteristics such as gender, age, and education level. The study entitled 'Access to antiretroviral therapy among HIV/AIDS patients in Khon Kaen Province, Thailand' (Kitajima et al., 2005) states there are few studies that have investigated whether access to ARVs is dependent on sociodemographic status. Information from such studies may be useful to improve the use of ARVs in developing countries. This means future research into access to ARVs may be valuable.

My study includes the topic of ARVs. The context is the early stage of implementation of the national programme launched by the government. It was implemented by hospitals of the Ministry of Public Health, and all patients could access ARVs in the form of GPO-Vir. The decision about whether to take ARVs had to be made by patients themselves. Treatment as usual was not affected for those patients that did not want to participate in the programme. Those patients who were selected to participate in this programme had to meet certain conditions. The discussion on ARVs in this study arises from the natural data on

⁶⁰ See more details of criteria for ARVs access and participation in Appendix E.

⁶¹ The 30-baht medical care programme was launched in April 2001. This programme was one of the headlines of populist Prime Minister Thaksin Shinawatra which helped him and his teams win a sweeping electoral victory in January 2001 (see Kittikanya, 2004).

the real practice of counselling. The following excerpt will give direction and determine the discussion throughout the rest of this chapter.

5.1 [06 – 08:04] [VIDEO]

[The patient was married previously and is now living with her new husband and children. She wished to participate in the ARV programme.]

1. Nurse: there must be the relative to
2. look after (.) in case (you)
3. have got allergy or any problem
4. (.) suppose that (the patient's
5. name) have been terribly allergic
6. right
7. Patient: right
8. Nurse: uh ((stretching hands)) in
9. detail.
10. Patient: ((nodding)) right
11. Nurse: ((touching the desk)) (I) will
12. get documents to show ((walking
13. to get documents)) there are
14. details ((searching for
15. documents))
16. Patient: ((moving forwards)) ((tidying
17. clothes up))
18. (17.4)
19. Nurse: they must read
20. Patient: ((looking at the wall))
21. Nurse: must read details also (21.0)
22. this is ((walking to sit)) there
23. must be an agreement for
24. participation in the programme
25. ((moving a chair forwards))
26. ((tidying hair up)) this
27. programme will be
28. Patient: ((moving forwards))
29. Nurse: the development programme and
30. follow up the health care
31. amongst HIV and AIDS patients
32. treated by (.) antiretrovirals
33. in Thailand ((touching face))
34. there must be a consent form for
35. signing as (I) told (you) we must
36. have blood test first (.) in this
37. consent form there will be
38. objectives of programme shown it
39. is for a patient who (.) has
40. never been treated by any
41. antiretrovirals
42. Patient: ((nodding)) ((nodding))
43. Nurse: ((stretching hand)) >like never
44. taken any antiretrovirals before<
45. Patient: ((nodding)) ((nodding))
46. Nurse: apart from a pregnant lady who
47. takes (.) for mother-to-child
48. transmission

49. Patient: ((looking outside))
 50. Nurse: this (.) a pregnant lady who used
 51. to take (drugs) can take this
 52. GPO-Vir (.) one will have a
 53. chance to be treated by
 54. antiretroviral drugs in the
 55. course of three GPO-Vir will make
 56. healthier and have better
 57. conditions of life ((looking at
 58. patient
 59. Patient: ((nodding))
 60. Nurse: this is the right of participant
 61. (.) first whether you would like
 62. to participate in the programme
 63. or not (.) it completely depends
 64. on your right ((stretching hand))
 65. (the patient's name) (you) have to
 66. think on your own
 67. Patient: ((nodding))
 68. Nurse: whether you will join it or not
 69. second (.) although you do not
 70. participate in the programme it
 71. would not be effective to your
 72. treatment and care both currently
 73. and in the future (.) this means
 74. that although ((stretching hand))
 75. (the patient's name) (.) suppose
 76. (you) consider its advantages and
 77. disadvantages (.) then (the
 78. patient's name) do not take these
 79. ARVs
 80. Patient: ((nodding))
 81. Nurse: (the patient's name) can still
 82. come to the hospital for all
 83. treatment
 84. Patient: ((nodding))
 85. Nurse: but that does not relate to
 86. antiretrovirals

The lengthy excerpt includes many themes for further discussion. This chapter aims to illustrate who initiates the topic of ARVs, and how it is brought up. In addition, the criteria for participating in the programme of ARVs is addressed. The core dilemma of disclosure and the decision to take ARVs is shown. Some patients hesitate to participate in the programme because they do not want to reveal their infection to any third person. I demonstrate how the nurse persuades the patients to take ARVs and how the nurse reassures her patient about what concerns the patient. This chapter aims to show only the relationship between disclosure and the decision to take ARVs. Other aspects of disclosure and discrimination will be discussed further in the next chapter. Last, I illustrate how information is delivered about health benefits and risks from taking ARVs.

5.2 Topic initiator

Before I discuss the different approaches to the issue of ARVs, which are demonstrated in counselling sessions, I explore ‘who’ initiates the topic regarding ARVs and ‘how’ this kind of topic is initiated. In institutional interaction, who speaks first can indicate the social structure in organisational conversation. This social structure is relevant to power, status and occupational role in institutions. Lay people and professionals treat these as significant in the course of their interaction (Schegloff, 1991, p.45 and Drew and Heritage 1992, p. 20). From this statement, it is possible that power, status and occupational role are applied in talk on ARVs; especially in determining who speaks first. The participant who speaks first might be regarded as the one who is most superior amongst those parties present. Atkinson (1982) points out that this is a common area in institutional talk. The person who speaks first is not decided only by preference of speaker; it is closely related to social structure, such as who is perceived to hold the most power, which determines who should initiate the topic of ARVs.⁶²

The data show that both patients and nurses initiate the topic. There is a quite significant number of patients who initiate the topic. The patients are more active, and this is different from talking about disclosure, confidentiality, sexuality and death and dying in other chapters. It is nearly one third of cases where patients initiate the topic, even though some of the nurses are initiators.

5.2.1 The number of initiators

The data here are based on 43 video counselling sessions. Eleven patients and 27 nurses initiated the topic of ARVs. The topic of ARVs was not addressed in 5 sessions. The way in which the topic was initiated is shown in table 2. In bringing the topic up, 2 patients⁶³ use a direct statement to request ARV services. Nine patients initiate the topic by responding to a prior turn of the nurse; this is called ‘initiative response’. Sometimes, the patient initiates the topic of ARVs to answer

⁶² This feature of ‘who’ initiates the topic is also discussed in the Chapters on Disclosure and Confidentiality, Sexuality and The Prospect of Death. In discussion of who is initiator of the topic the same concept applies that speaking first may be related to the status of the speaker.

⁶³ The patients of case no.06 and no.13 initiated the topic of ARVs. They used a direct question to request ARVs.

a question, and sometimes they refer to the use of ARVs to a response made by the nurse. The phrases used by patients to bring the topic up appear in the table 3.

Table 2. The number of topic initiators

Initiator	Request	Initiative response	Response to inquiry	Persuasion	Follow-up	Total
Patient	2	9				11
Nurse			1	11	15	27
						Total 38

Total no. of consultations was 42 but in 5 instances this topic was not discussed.

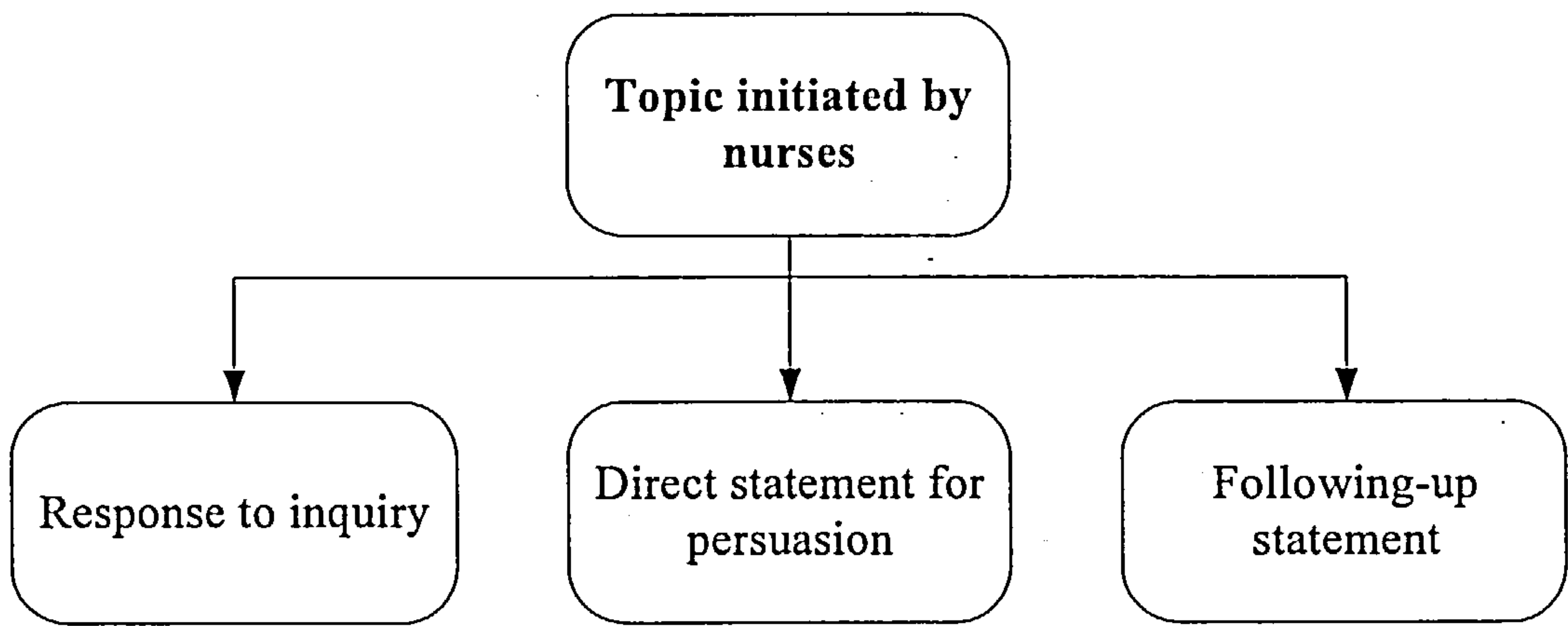
Table 3. The patient brings the topic into discussion

Direct question for requesting	Initiative response
a. Have you got them (.) drugs?	a. I took AZT to my daughter
b. Have you got any medicines doctor if suppose need ARVs	b. right (.) I (.) resigned for taking antiretrovirals
	c. if my husband had taken ARVs, he should have survived
	d. if CD4 is lower than 200, I will take ARVs etc.

There are three main reasons for nurses in initiating the topic. First, the nurse may mention the topic by responding to an inquiry of a patient. The patient may have heard about ARVs. The patient does not ask about ARVs indirectly, but in the sense the patient inquiries and indirectly initiates the talk. Then the nurse has taken an opportunity when the patient inquiries to initiate the topic. Second, the nurse may wish to persuade the patient to participate in the programme. Third, the nurse may need to follow up on what a patient has encountered after initiating

a course of ARVs. This is because, as well as making the patient healthier, ARVs may cause side-effects such as allergic reactions, for example fever, rashes, dizziness, loss of appetite, and vomiting. Three categories in which the nurse initiates the topic are shown in diagram 5.

Diagram 5. Three categories of the way in which the nurse initiates the topic of ARVs



Response to inquiry

- a. We have already had ARVs.

Direct statement for persuasion

- a. After we have ARVs, and you have seen them taking and become better what do you think?
- b. Would like to apply for the use of drugs?
- c. Do you know that we have already had the programme of ARVs?

Following-up statement

- a. Have you got any problems since you have participated in the programme?
- b. How is your health?
- c. Are you still taking ARVs?
- d. After you have taken these drugs, how have you been?
- e. After participating in this programme, how do you feel?
- f. When did you start ARVs?

g. After you have taken ARVs, you have not had any side effects have you? etc. The following examples are shown to underpin what has been discussed. The first example shows the patient has known about ARVs before. Consequently she initiates the topic with a direct request for ARVs.

5.2 [13 – 07:31] [VIDEO]

[The patient's husband was aware of the patient's infection. The patient and her husband previously discussed abortion with this nurse; this session was recorded on audio cassette. The patient still worries and this time, she came to see the nurse for ARVs; this session was recorded on video camera.]

- | | | |
|-----|----------|---|
| 1. | Nurse: | orr::((nodding)) ((raising one |
| 2. | | shoulder)) (3.0) anything else |
| 3. | | (2.0) no problem for financial |
| 4. | | matter and have got anything else |
| 5. | | (1.0) could help |
| 6. | Patient: | → hhh ((wiping nose)) (2.0) have |
| 7. | | → got any medicines doctor ⁶⁴ if |
| 8. | | → suppose (.) need antiretrovirals |
| 9. | Nurse: | ah:: antiretrovirals ((pointing)) |
| 10. | | it is good that (.) asked |
| 11. | | ((walking to get documents)) |

At 07:31 minutes, in lines 6-8, the patient initiates the topic. She asks the nurse for the use of ARVs by using a direct request in stating 'hhh ((wiping nose)) (2.0) have got any medicines doctor if suppose need antiretrovirals'. The next example also illustrates the topic being initiated by the patient, but using an initiative response.

5.3 [23 – 01:10] [VIDEO]

[The counsellor was a health educator. The patient was a widow, and a single mother. She was on the ARV programme.]

- | | | |
|----|----------|-------------------------------------|
| 1. | Patient: | no not working (I) resigned already |
| 2. | Nurse: | ah ((relaxing)) have already |
| 3. | | resigned |
| 4. | Patient: | ((tossing head)) right |
| 5. | Nurse: | what's the matter? |
| 6. | Patient: | right (.) I (.) resigned for taking |
| 7. | | antiretrovirals |

In example # 5.3, at 01:10 minutes, the patient responds to the nurse's question as

⁶⁴ Some patients in rural area address medical staff such as a nurse as a doctor. This seems to show the medical staff are in higher status than some patients.

to why she had to resign from her job. The patient told the nurse that she resigned from her current job because she had decided to take ARVs. Here, it is important to elaborate that once the patient began to take ARVs, she had to be followed up regarding side-effects. This necessitated frequent visits to the hospital. The patient did not want to be absent from her workplace for each follow-up visit, so she decided to resign before beginning the course of ARVs.

As nurses are more commonly the initiators of the topic, the following two examples demonstrate the way the topic is initiated by them. The first example shows the nurse using a direct statement to respond to an inquiry of the patient. Before the nurse initiates the topic, the patient mentions it. It is possible this patient may have heard about ARVs. But he may need the nurse to take the lead about the use of ARVs.

5.4 [02 – 12:09] [VIDEO]
[The patient was diagnosed with schizophrenia. He was divorced from his wife. He was not on the ARV programme.]

- | | | |
|----|----------|---------------------------------------|
| 1. | Patient: | and ((pointing)) how we find any |
| 2. | | → drugs to fight against it |
| 3. | Nurse: | → ((tossing head)) ((tossing head)) |
| 4. | | → but nowadays we have already had |
| 5. | | → ((nodding)) <u>anti:retrovirals</u> |

The above excerpt illustrates the nurse initiates the topic by responding to the turn of the patient. The patient mentions drugs as shown in line 2. The nurse initiates the topic by informing the patient that there are ARVs for treatment stating ‘((tossing head)) ((tossing head)) but nowadays we have already had ((nodding)) anti:retrovirals’ as shown in lines 3-5. The way in which the nurse introduces the topic seems abrupt as it is initiated without first expressing sensitivity. The awareness of sensitivity around ARVs seems to be different from that in other chapters. In discussing ARVs, the data show that co-participants do not deal with sensitivity.

The next example shows the nurse initiate the topic. However, the way in which the nurse introduces the topic may indicate that this patient has heard about the use of ARVs before.

5.5 [15 – 01:45] [VIDEO]

[The counsellor was a midwife. The patient was a widow. She was not on the ARV programme.]

- | | | |
|----|----------|------------------------------------|
| 1. | Nurse: | first of all (.) I would like |
| 2. | | (1.0) ((moving glasses)) (5.0) |
| 3. | | THAT nong (.) would like to apply |
| 4. | | for taking drugs ((turning to the |
| 5. | | patient)) is it ((nodding)) ↑right |
| 6. | Patient: | ((nodding)) ((nodding)) apply for |
| 7. | | taking drugs. |

The data show that the nurse initiates the topic by stating that the patient would like to apply for the programme of ARVs use. The next example also shows the topic initiated by the nurse. The nurse initiates the topic of ARVs to follow up on the patient’s experience of the ARV programme since he began participating in it.

5.6 [18 – 11:35] [VIDEO]

[The counsellor was a midwife. The patient was single. He was on the ARV programme.]

- | | | | |
|----|----------|---|----------------------------------|
| 1. | Nurse: | → | (name of patient) after |
| 2. | | → | participating in the programme |
| 3. | | → | ((clasping hands together)) |
| 4. | | → | ((turning to patient)) of |
| 5. | | → | antiretrovirals (1.0) how do |
| 6. | | → | ((nodding)) feel about this |
| 7. | | → | programme |
| 8. | Patient: | | ((slightly nodding)) ((nodding)) |
| 9. | | | that’s good |

At 11:35 minutes, the nurse brings the topic by asking a direct question about the patient’s physical reactions to ARVs. In lines 1-7, the nurse asks how the patient feels after participating in the programme. Follow-up on the use of ARVs is found frequently in my data because many patients had already begun taking ARVs. The nurse makes attempts to persuade those patients that have not already begun taking ARVs. Each patient gives different reasons for participating in the programme. In the next section, I discuss the patient’s reasons for participating in the programme.

5.3 Accountability for participating in the ARV programme

Amongst patients, there are two major accounts for participating in the programme: first, universally most patients wish to live longer, and second some patients wish to live longer and stronger. When they become stronger, they can support their family and children. They expect to see their children to a bright future. The first following example shows a male patient who wishes to use ARVs in the hope that he would live longer.

5.7 [04 – 12:15] [VIDEO]

[The counsellor was a midwife. This patient was a male homosexual. He used to be involved with commercial sex work in Bangkok. He was not on the ARV programme. He helped his sister run a business. To some extent, his infection affects his business.]

- | | | | |
|-----|----------|---|-----------------------------------|
| 1. | Nurse: | | then after there are drugs |
| 2. | Patient: | | .hhh |
| 3. | Nurse: | | you saw others else ((stretching |
| 4. | | | hand)) taking drugs and better |
| 5. | | | what do you think? |
| 6. | Patient: | | think that (.) if ((nodding)) |
| 7. | | | ((nodding)) ((nodding)) |
| 8. | | → | ((nodding)) take will live longer |
| 9. | Nurse: | | ((tossing head)) ((tossing head)) |
| 10. | Patient: | → | want to spend life longer |
| 11. | Nurse: | | ((tossing head)) |
| 12. | Patient: | → | ((nodding)) live longer and then |
| 13. | | → | at home (.) sometimes economics |
| 14. | | → | are not good (.) business is not |
| 15. | | → | good |

The above excerpt shows that the patient needs to live longer to support his family. He told the nurse that if he took ARVs, he should live longer and he might be able to improve the financial situation at home as shown in lines 8, 10, and 12-15. This case shows a common purpose for taking ARVs; most patients would like to live longer. Frequently patients wish to live longer for some defined purpose. My data also show that the female patients who look after their children, as most other female patients do according to Thai social structure, show a need to take ARVs to live longer for their children. The subsequent example shows a young female patient who wishes to take ARVs because she wishes to live longer with her son.

5.8 [27 – 12:29] [VIDEO]

[The patient was a 17 year old widow, and a single mother. She was living with her parents. She wished to participate in the ARV programme.]

1. Nurse: then about decision on taking ARVs
2. Patient: ((smiling)) (I) would like to live
3. longer
4. Nurse: ((tossing head))
5. Patient: taking them
6. Nurse: ((tossing head)) have got a son
7. also ((tossing head))
8. Patient: ((nodding)) right (1.0) a son

The above excerpt shows that the female patient is a carer. She looks after her son. This patient told the nurse that she wished to take ARVs because she would like to live longer.

Whilst access to HIV/AIDS medicines is promoted for all patients, most patients who wish to live longer for themselves, family, community and country show their need for ARVs through conversation. However, participation in the programme is restricted by some conditions. In order to be selected to join the programme, patients have to show that they meet basic requirements. The next section demonstrates what criteria and conditions the patient should meet to gain permission to use ARVs.

5.4 Physical conditions for eligibility

The patient will be told in detail what physical condition he or she has to have before they are given permission for participating in the programme. The patient must have a blood test and CD4 count and this is a strict formal requirement. The patient will be assessed about their behaviour. This seems to be an informal criteria which the nurse applies in selecting patients, and is not found in the documents describing the ARV programme. However, these restrictions are found in my data. The document supplied by hospitals only asks whether the patient is involved with any social activities, and whether the patient contributes to society or not. The patient is expected to show their social responsibility; they must not spread infection. In addition, the patient has to share their success from taking ARVs; the patient is asked to be a role model for other patients. In this

area, most counsellors told me that a role model is important in convincing patients who are considerably afraid of side-effects. Unfortunately, there is only one example covered in the data.

5.4.1 Blood tests

The major criterion for participating in this programme is a blood test to have a CD4 count⁶⁵. The patient will be given permission to participate in the programme if their CD4 count is lower than 200. Typically, a patient who has a CD4 count below 200 is regarded as a rather weak patient, and he or she may have some severe symptoms. The following examples show that the CD4 cell count is the major criterion for the use of ARVs.

5.9 [28 – 44:55] [VIDEO]
[The counsellor was a midwife. The patients were brother and sister; the younger sister was infected before her elder brother. Neither patient was on the ARV programme.]

- | | | | |
|----|-----------------|---|---------------------------------|
| 1. | Nurse: | → | ((touching breast)) if our body |
| 2. | | → | (.) CD4 is higher than 200 |
| 3. | Female patient: | | ((nodding)) |
| 4. | Nurse: | → | drugs ((waving hand)) we cannot |
| 5. | | → | take |
| 6. | Female patient: | | ((nodding)) |

At 44:55 minutes, the nurse informed both patients about the criteria for taking ARVs. In lines 1-2, and 4-5, the nurse told the patients that if they had CD4 cell counted, and it appeared higher than 200, patients do not need to take ARVs. This indicates that the patients are still healthy, and they could continue to live as normal. My data also show the nurse denying access to some patients because they did not meet this requirement. The following example show the same nurse does not give permission to take ARVs to one patient.

5.10 [39 – 21:13] [VIDEO]
[The counsellor was a midwife. The female patient was a widow, and a single

⁶⁵ Patients have to pay 200 bahts (approximately £3.00) for a CD4 count to judge their eligibility. After the patient is selected to participate in the programme, the patient does not need to pay for CD4 counts as it is covered by the programme. The cost for CD4 cell counts differs between hospitals in each province.

mother. She was not on the ARV programme.]

1. Nurse: then ((shaking head)) for you
2. girl (.) not let to take ARVs
3. because CD4 [669
4. Patient: [((nodding)) right

The above excerpt illustrates that the patient is not allowed to take ARVs because she is still healthy. Her CD4 count is much higher than 200. Apart from CD4 cell count, the social responsibility the patient takes is also an important condition.

The nurse may assess how her patient behaves and whether it is worth taking ARVs. The nurse has included this aspect for gaining permission to take ARVs as part of her public health role. In this respect, this condition is not written down in a form for application for participating in the programme or on a consent form. Instead, this condition has been observed in my data.

5.4.2 Social responsibility

The condition about social responsibility centres on the fact that patients must not spread infection. This condition is brought into discussion and becomes salient with the nurse playing a public health role, as well as a counselling role. The first example shows the nurse concerned with the spread of infection. The nurse brings it up in connection with participation in the programme.

5.11 [27 – 28:59] [VIDEO]

[The patient was a 17 year old widow, and a single mother. She was living with her parents. She wished to participate in the ARV programme.]

1. Nurse: nowadays (.) ask you frankly
2. Patient: ((nodding))
3. Nurse: staying at home (.) about sexual
4. intercourse ((moving hand)) have
5. you ever had it?
6. Patient: ((shaking head)) no (.) right
7. Nurse: with others?
8. Patient: ((nodding)) right
9. Nurse: → um::((nodding)) when once you
10. → participate in the programme (.)
11. → you will not have to spread
12. → infection (.) to others (1.0)
13. → ((nodding))
14. Patient: ((nodding))
15. Nurse: one thing although you have

16. taken drugs (.) still have it
 17. indeed you can spread infection
 18. to others
 19. Patient: right
 20. Nurse: → do not have sexual intercourse
 21. → ((stretching hand)) even with
 22. → other infected people
 23. Patient: ((nodding))
 24. Nurse: it is not effective
 25. Patient: ((nodding))
 26. Nurse: then cannot ((shaking head))
 27. hold up virus but ((moving hand in
 28. and out)) you bring other viruses
 29. in too

The above excerpt shows the nurse reminds her patient about the spread of infection. The nurse informed the patient that if she decides to take ARVs and is selected for it, she must not spread infection as shown in lines 9-13 stating 'um:: ((nodding)) when once you participate in the programme (.) you will not have to spread infection (.) to others (1.0) ((nodding))'. This seems to show that an opportunity of taking ARVs is correlated to how the patient behaves. The nurse provides the patient with further information that once the patient has taken ARVs, the virus is still in her body and she can spread it to others. The nurse does this in order to clarify the point and prevent the patient from misunderstanding that taking ARVs is equivalent to a cure. Indeed, ARVs work by decreasing viral loads. The nurse informed the patient further that she could not have sexual intercourse even with other infected people (lines 20-22). However, the excerpt shows that the nurse does not state explicitly that social responsibility is a criterion for permission to take ARVs. At the end of the sequences, the nurse refers to the reason why having sexual intercourse can make the patient worse off because she may obtain other viruses. The next example shows more clearly the association between social responsibility and permission for taking ARVs.

5.12 [43 – 01:00:03] [VIDEO]

[The counsellor was a midwife. The patient was a homosexual male patient. He was not on the ARV programme. He passed away after the researcher left the research site.]

1. Nurse: not ((shaking head)) every
 2. patient ((stretching hands))
 3. will have side effects (.)

4. others have not had anything (.)
 5. → look at others ((mentioning other
 6. → three patients' name)) (2.0)
 7. → is it ((nodding)) ↑right?
 8. Patient: ((nodding)) ((smiling))
 9. ((nodding))
 10. Nurse: it ((raising hands)) did not
 11. happen to every patient (.) so
 12. do not worry anything has not
 13. → yet (.) but:: will tell
 14. → ((pointing a patient)) you one
 15. → thing ((putting hand on the
 16. → desk)) that a person ((pointing a
 17. → patient)) who behaves like this
 18. → (.) always ((pointing))
 19. → encounters a severe effects
 20. [((lifting a glass))
 21. Patient: [((raising eyebrow)) ((grinning))
 22. ((laughing)) ()
 23. Nurse: karma ((raising eyebrows)) exists
 24. ((drinking water))

The above excerpt shows that the patient worries about the side effects of ARVs. The nurse convinces him by stating that he does not need to worry about it because side effects do not occur for every patient. Importantly, on average patients become better through taking ARVs. One technique the nurse uses to convince the patient is that of referring to other patients' outlooks. The nurse does this in lines 5-7 stating, '...look at others ((mentioning other three patients' name)) (2.0) is it ((nodding)) ↑right?'. However, the nurse reminds the patient about his social responsibilities before he can participate in the programme. She reminds the patient that he might encounter severe side effects if he does not behave well as shown in lines 13-19. One aspect to be discussed further is the way in which the nurse reminds and refrains her patient from spreading infection. The nurse uses pointing. She points directly forwards to the patient twice as shown in lines 14 and 16-17. This action seems to show that the nurse is trying to control the patient's sexual behaviour. In the prior turns, the nurse and the patient discussed the sexual behaviour of the patient. The patient has ignored his social responsibilities and spread infection to his sexual partners. He rarely used condoms when he had sexual intercourse in the form of a gang bang with other young sexual partners. The discussion on this patient's sexual behaviour is shown in further detail in Chapter Seven.

In addition, the nurse wants her patient to be a role model. The data show

that some patients did not experience allergic reactions from taking ARVs. Consequently, they can take part in the programme by encouraging others to participate.

5.4.3 Role model

The patient is approached to tell his or her story about their success from taking ARVs. The following example shows that the nurse asks for the patient's co-operation to inform others of her positive results from taking ARVs. This female patient revealed that her health improved greatly after taking ARVs. Before she took ARVs, she was allergic to many substances. She had spots from insect bites and she could not even wear tampons.

5.13 [12 – 06:24] [VIDEO]

[The patient was a widow, and a single mother. She was on the ARV programme.]

- | | | |
|-----|----------|--------------------------------------|
| 1. | Nurse: | If we are together ((putting |
| 2. | | hands together)) ((separating |
| 3. | | hands)) |
| 4. | Patient: | ((nodding)) |
| 5. | Nurse: | → want (name of patient) to tell |
| 6. | | → ((moving two hands around)) |
| 7. | | → (name of patient) can tell ↑right? |
| 8. | Patient: | ((nodding)) can tell |
| 9. | Nurse: | ((tossing head)) uh (.) uh |
| 10. | Patient: | can |
| 11. | Nurse: | because |
| 12. | Patient: | ((touching head)) |
| 13. | Nurse: | → other people will know (.) |
| 14. | | → someone does not understand |
| 15. | Patient: | ((nodding)) |
| 16. | Nurse: | then they do not ((nodding)) take |
| 17. | | them |
| 18. | Patient: | ((nodding)) right |

In lines 5-7, the nurse needs the patient to tell other patients of her success when they have the next meeting. The patient agrees to do so. The nurse told the patient that her information may encourage other patients to decide upon the ARV programme. Some patients do not understand about the use of ARVs as shown in lines 13-14.

While the patient may meet the physical criteria and requirements for

taking ARVs, some patients may still hesitate to participate in the programme if they are required to find a witness to sign a consent form. This is because in order to obtain a witness, they have to reveal their infection. This is a core dilemma for patients, as I illustrate next.

5.5 Disclosure: a dilemma before taking ARVs

Despite the fact that treatment by antiretroviral drugs can be accessed by all patients, some patients do not feel free to take them. In other words, a patient may be reluctant to take ARVs if he or she has to reveal the infection to others. According to regulations and orders placed by the Ministry of Public Health, each patient should reveal their infection to someone who is formally permitted to sign a consent form as a witness. The term 'someone' means anyone the patient can trust; they may be parents, sister, brother, niece, nephew, daughter, son, relatives or friend. Importantly, this witness should know what kind of drug the patient is taking, and be able to look after the patient in the case of an emergency. For example, the patients should be accompanied to the hospital if they become ill through side effects from taking drugs. This means that the patient has to reveal the infection to at least one person. This dilemma for patients is represented in my data and in ethnographic data at the time of data collection. I had an opportunity to participate in a follow-up meeting for the ARV programme in March 2003 at the provincial hospital. Most counsellors reported to the meeting that patients hesitated to participate in the programme. There were many places left unfilled as a result. The dilemma encourages the patient to pursue scepticism by asking her counsellor how far she has to reveal her infection or from whom she can keep secret her infection. This indicates that the patient wishes to feel secure in terms of their infection and confidentiality before they decide to take ARVs. The first excerpt shows that the patient does not want her husband to know her infection.

5.14 [06 – 15:54] [VIDEO]

[The patient was married previously and is now living with her new husband and children. She wished to participate in the ARV programme.]

1.	Nurse:	I would like to explain that not
2.		everyone can take ((putting
3.	→	documents on a desk)) there must
4.	→	have the relative too
5.	Patient:	((nodding)) ((nodding))
6.	Nurse:	((tidying leaflets up)) have to
7.		take drugs on time (1.0) will
8.		be given drugs to take too (2.0)
9.		regarding this what will (the
10.		patient's name) ↑do (.) have not
11.		told the relative.
12.		(7.2) .
13.	Patient:	→ I really worry (.) afraid that
14.	→	relatives will ((nodding)) know
15.	Nurse:	um::
16.	Patient:	→ ((nodding)) °afraid that the
17.	→	husband will know°

In lines 3-4, the nurse told the patient that the patient must have a relative involved if she wished to participate in the programme. The patient's response shows that the patient has a dilemma on this matter because she is afraid that her relatives will know that she has been infected as shown in lines 13-14.⁶⁶

Importantly, the patient's last turn shows that she still hides her infection in her family because she is afraid that her husband will find out in lines 16-17. This case shows clearly that participating in the programme brings the patient the dilemma because the patient has to reveal infection. Revelation of infection can put some patients at risk of discrimination.

The next example shows the dilemma of another patient. She worries about revelation of her blood test result. The patient initiates the topic of ARVs by directly requesting them. However, she asked the nurse whether she could have the blood test for a CD4 count in the hospital where she was living.

5.15 [13 – 10:42] [VIDEO]

[The patient's husband was aware of the patient's infection. The patient and her husband previously discussed abortion with this nurse; this session was recorded on audio cassette. The patient still worries and this time, she came to see the nurse for ARVs; this session was recorded on video camera.]

1.	Patient:	can ask for test ↑here ((pointing
2.		down))
3.	Nurse:	come to test here (.) I have to
4.		make an appointment now I have

⁶⁶ This patient looked very pale when she mentioned about revelation of infection. She was really afraid that husband would find out about her infection. Her worries can be seen clearly on the video.

5. not got enough number ((touching
 6. ear))
 7. Patient: right ((nodding))
 8. Nurse: because I have got 6 ((pointing))
 9. left I have got quota for 6
 10. Patient: right ((nodding))
 11. Nurse: one (.) went to have own test (.)
 12. so have got 5 right 5 left
 13. ((showing hand)) and today (.)
 14. came to see me there were 4 if
 15. all 4 do at the same time that
 16. would be great (.) sometimes it
 17. is not at the same time
 18. Patient: → ((touching lip)) just like do
 19. together (.) at the same time

After the topic was opened up by the patient by her request for ARVs as shown in example # 5.2, the patient shows her worries about revealing infection. At 10:42 minutes, the patient asks the nurse whether she can choose to have a CD4 cell count at this local hospital. The data show that her request is indirectly denied. She is told that it is necessary to make an appointment if she wishes to have a blood test at the local hospital. This indicates that the nurse tries to convince her to have the test at the provincial hospital. The patient is told that she has to wait until the nurse makes an appointment with other patients for a blood test at the same time. The patient does not agree with what the nurse proposes immediately. The patient shows she still worries, as shown in line 18. The way in which the patient expresses her worries is by touching her lip. Touching a lip is, in this context, a gesture projected to delay thinking.

Another case is no. 35 in which the patient is a monk. He has a dilemma about revealing his infection by contacting other medical staff for ARV drug services. The patient did not want to see the medical staff in the hospital in his home area and had chosen to visit the provincial hospital instead.

5.16 [35 – 31:54] [VIDEO]

[The patient was a monk. He wished to participate in the ARV programme.]

1. Nurse: what do Than Jao think (.) what
 2. I have said?
 3. (4.0)
 4. Patient: → but if go to get them at (name of
 5. hospital) there ((slightly moving

6.		→	legs)) doctor ⁶⁷ will keep it
7.		→	↑confidential
8.	Nurse:	→	((slightly nodding)) ((quickly
9.		→	looking straight)) but I (.) but
10.		→	I think that ((moving hands)) I
11.		→	will find means to make them
12.		→	(1.0) <u>keep confidential</u> your
13.		→	infection

The patient shows his worries about contacting anybody at the hospital in the area where he was living because he was afraid of discrimination if his infection was revealed. Thus he asks for co-operation from his counsellor to hide his infection in stating ‘but if go to get them at (name of hospital) there ((slightly moving legs)) doctor will keep it ↑confidential’ in lines 4-7. The word ‘doctor’ is a noun, which the patients and relatives in some rural areas use to address medical staff. At this point, the patient is successful because the nurse agrees with him about hiding his infection in stating that she can find a strategy to keep his infection confidential in lines 8-13 stating ‘((slightly nodding)) ((quickly looking straight)) but I (.) but I think that ((moving hands)) I will find means to make them (1.0) keep confidential your infection’. The nurse accepted to keep his infection confidential by co-operating with the staff of another hospital.

Patients concerned about confidentiality do not want to reveal their infection to a third person. The nurse does not coerce them to reveal infection as it is the patient’s right to decide whether or not to tell anyone. The data demonstrate that decisions about taking ARVs are not made immediately by patients. Some patients hesitate to participate in the programme if they find themselves in a dilemma about the revelation of infection. Although the nurse realizes that some patients have difficulties in joining the programme, participation in the programme is beneficial to the patient. Consequently, nurses make an attempt to persuade patients to take ARVs. At the same time, nurses have to reassure patients about confidentiality, which is of concern to patients. In the next section, I discuss persuasion and reassurance.

⁶⁷ The word ‘doctor’ is a noun, which the patients and relatives in some rural areas use to address medical staff.

5.6 Persuasion and reassurance

The data show that the nurse persuades the patient to reveal their infection to someone close. The way in which the nurse persuades the patient is to let the patient voluntarily reveal their infection. The nurse does not force her patient. In addition, at this stage, there are reassurances involved in the discussion; they cover two areas. First, the nurse reassures the patient that she will keep infection confidential if the patient does not want to let anybody else know. Another reassurance is conducted by the patient themselves. Patients reassure themselves of confidentiality by asking for assistance from a counsellor. The following example illustrates how the nurse persuades her patient to reveal infection to her husband because the nurse wants the patient to participate in the programme. The way in which the nurse persuades the patient to do so is based on the self-determination of the patient.

5.17 [06 – 17:50] [VIDEO]

[The patient was married previously and is now living with her new husband and children. She wished to participate in the ARV programme.]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | | then when will (the patient's |
| 2. | | | name) tell him? Do you think to |
| 3. | | | tell him? |
| 4. | | → | (2.3) |
| 5. | Patient: | → | think that (.) will not tell him |
| 6. | | → | (2.4) I am afraid that he will |
| 7. | | → | kick me out |
| 8. | Nurse: | | uh:: you will not ((shaking head)) |
| 9. | | | tell him right. |
| 10. | Patient: | | right right (.) I worry about the |
| 11. | | | child |
| 12. | Nurse: | | when will (the patient's name) |
| 13. | | | tell him? |
| 14. | | | (8.4) |
| 15. | Patient: | | I will not tell him at all |
| 16. | Nurse: | | will not ((shaking head)) tell |
| 17. | | | him right? |
| 18. | Patient: | | ((nodding)) right |
| 19. | Nurse: | → | >this depends on (the patient's |
| 20. | | | name)< |
| 21. | Patient: | | right |

At 17:50 minutes, the nurse asked the patient whether she would tell her husband about her infection. The patient delayed answering the question, and seems to

deny in the negative. She has not done it immediately. She produced a pause of two and three tenths seconds as shown in line 4 before stating that she would not tell him about her infection. Her explanation for hiding her infection was that she was afraid of being left as shown in lines 5-7. In addition, she worried about the consequences for her child if she had to move elsewhere. The nurse expected her patient to tell her husband, but she did not show her intention obviously. She asked her patient when the patient would tell her husband. The patient confirmed again that she would not tell him at all. When the nurse's action is blocked by the patient's regular answers and incessant refusal to tell her husband, the nurse has to move to use another technique. The nurse uses a voluntary technique; this technique is used in line 19. The nurse told her patient that the decision to tell others about infection depends on the patient herself. The nurse elaborated further that she also kept the patient's infection confidential. The patient could choose whether or not to tell her husband.

5.18 [06 – 20:39] [VIDEO]

1.	Nurse:		about one who will sign in the
2.			form (.) we will talk
3.	Patient:		((nodding))
4.	Nurse:		about it again
5.	Patient:		I will discuss it with other
6.			staff again (.) I will let them
7.			know about it (.) but (.)
8.			whether to tell or not to tell
9.			the husband (.) that you will
10.			not tell him
11.	Patient:		((shaking head))
12.	Nurse:	→	it depends on the right of
13.			(the patient's name)
14.	Patient:		((nodding)) right
15.	Nurse:		but our hospital will not
16.			definitely reveal
17.	Patient:		((nodding))
18.	Nurse:		do not worry about it
19.	Patient:		((nodding))
20.	Nurse:	→	If parents (.) relatives (.)
21.		→	husband come to ask me (.) I will
22.		→	not tell them
23.	Patient:		((nodding))
24.	Nurse:	→	so do not worry about it
25.	Patient:		((nodding)) ((nodding)) right
26.	Nurse:		like ((moving hand)) we come to
27.			talk in general
28.	Patient:		right

At 20:39 minutes, the excerpt shows the reassurance from the nurse. The nurse told her patient that they would discuss the issue of finding a witness at another time. In line 12, the nurse told the patient that it is the right of the patient to choose whether or not to tell anyone else. The hospital always keeps the patient's infections confidential, and so the patient does not need to worry about that. The hospital definitely makes the patient feel secure, and has never put the patient at risk by revealing her infection. Although the patient's parents, relatives and husband suspect about her illness, the infection is kept entirely confidential. The nurse reassures her patient; this as shown in lines 20-22 stating 'If parents (.) relatives (.) husband come to ask me (.) I will not tell them'. At the end of the nurse's turn , as shown in line 24, she produces 'so do not worry about it' in an imperative form in order to make the patient feel less worried. At the end of excerpt, the nurse shows how she hides the patient's infection. She told the patient that she and the patient would talk in general rather than specifying any topics. The next excerpt shows the reassurance conducted by both.

5.19 [06 – 21:30] [VIDEO]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | → | I will ask someone to bring a |
| 2. | | → | letter |
| 3. | Patient: | | ((nodding)) tell (.) tell that |
| 4. | | | (the patient's name) please go |
| 5. | | | to see the doctor |
| 6. | Nurse: | | uh ((tossing head)) will tell that |
| 7. | | → | tell (the patient's name) to go |
| 8. | | → | to see the doctor |
| 9. | Patient: | | ((nodding)) |
| 10. | Nurse: | | probably tell to get medicines |
| 11. | Patient: | | ((nodding)) |
| 12. | Nurse: | | ah ((tossing head)) get more |
| 13. | | | medicines (1.0) right ((nodding)) |
| 14. | | | your card is put in front |
| 15. | | | ((pointing)) waiting for |
| 16. | Patient: | | ((nodding)) |
| 17. | Nurse: | | go to see the doctor (.) check |
| 18. | | | everything ((moving hand around)) |
| 19. | | | right ((nodding)) |
| 20. | Patient: | | right ((nodding)) |
| 21. | Nurse: | | If there is anything (.) will |
| 22. | | | contact you (.) regarding reagent |
| 23. | | | ((pointing)) |
| 24. | Patient: | | ((nodding)) |
| 25. | Nurse: | | If you have got anything unhappy |
| 26. | | | (.) come back to see me in this |
| 27. | | | room |
| 28. | Patient: | | ((nodding)) |
| 29. | Nurse: | | I will stay here all working times |

30. Patient: right
31. Nurse: except weekends or national
32. [holidays.
33. Patient: → [suppose (.) if write a letter
34. Nurse: uh
35. Patient: say that (.) (the patient's name)
36. comes to (name of the hospital)
37. urgently
38. Nurse: right it' s alright
39. Patient: → say this better than mentioning
40. → reagent ((nodding))

At 21:30 minutes, the excerpt illustrates the reassurance conducted by co-participants. The nurse makes an attempt to render the patient happy and secure. The nurse shows the way in which she helps the patient hide infection. The nurse would send a letter saying the patient has been told to see the doctor as shown in lines 1-2, and 7-8. The patient has to come to the hospital to get medicines. The nurse told the patient that if the patient worries about anything, the patient can come to see her at the same place. However, the patient still worries until the last minute about disclosure of infection. She is assured that the content of the letter should be written to make her secure. The way in which she shows her worries is to produce overlapping utterances in stating '[suppose (.) if write a letter' as shown in line 33. She told the nurse that she prefers mentioning about seeing the doctor rather than saying about reagent as shown in lines 39-40.

The following example shows how the nurse persuades her patient to participate in the programme, and the nurse reassures her patient.

5.20 [13 – 12:15] [VIDEO]

[The patient's husband was aware of the patient's infection. The patient and her husband previously discussed abortion with this nurse; this session was recorded on audio cassette. The patient still worries and this time, she came to see the nurse for ARVs; this session was recorded on video camera.]

1. Nurse: >but still healthy nowadays<
2. → ((touching the patient's leg))
3. ((smiling))
4. Patient: right ((nodding))
5. Nurse: but I understand still worry
6. → ((tapping the patient's leg))
7. ↓right
8. Patient: ((nodding))
9. Nurse: but to be happy ((tapping the
10. patient's leg)) have test
11. Patient: ((nodding))
12. Nurse: if it is low then will take drugs

13. ((retracting hand)) (1.0) these
 14. are free drugs
 15. Patient: ((nodding)) .hhh

The above excerpt shows that the patient is encouraged to have a blood test. However, before the patient is told she must have a blood test, she is encouraged by the nurse. The way in which the nurse encourages her patient is by touching the patient's leg, as shown in line 2, and telling the patient that she is still healthy, but still worried. Thus, in order to make the patient feel less stressed, the nurse recommends that she have a blood test. The way in which the nurse stresses the importance of the blood test is by tapping the patient's leg, as shown in line 6. Then the nurse states that if the patient's CD4 cell count is lower than 200, the patient should be permitted to take drugs. Importantly, taking those drugs is free of charge. The nurse does not directly convince her patient to take drugs and to have a blood test. In other words, she encourages the patient first and probes further about her healthy look. Finally she refers to assurance before she tells her patient to have a blood test. This represents a smooth tactic used by the nurse in convincing the patient to have a blood test before taking drugs. In the following sequences, the nurse convinces her patient how effective the drugs are by referring to another patient.

5.21 [13 – 14:41] [VIDEO]

1. Nurse: there is our patient saying that
 2. after taking these drugs it is
 3. better
 4. Patient: ((nodding))
 5. Nurse: previously she had got spots
 6. ((pointing at one hand)) when
 7. mosquitoes bit there were spots
 8. Patient: uh ((nodding))
 9. Nurse: she scratched terribly
 10. ((scratching))
 11. Patient: ((nodding))
 12. Nurse: but now it is about 2 months
 13. ((pointing)) she has taken drugs
 14. Patient: ((nodding))
 15. Nurse: under this programme she said (.)
 16. that (.) take only one it is
 17. better no spots ((touching arm))
 18. Patient: right ((nodding))
 19. Nurse: furthermore she said when she had
 20. to put on a tampon (.) she would
 21. be allergic to (.) any brands
 22. Patient: uh

23. Nurse: after taking these drugs there
 24. was nothing ((slightly shaking
 25. head)) at all not allergic to a
 26. tampon (.) even the same brands
 27. no allergy
 28. Patient: ((nodding))

The data show that the nurse convinces her patient of the efficiency of the drugs. The nurse refers to another patient whose condition improved after she decided to participate in the project. The nurse refers to two main difficulties, which the patient who was referred to used to experience. The nurse told the patient that the other patient experienced allergic reactions when she was bitten by mosquitoes. This resulted in a lot of spots along her arms and those caused her terrible itching. The other patient was also allergic to the use of tampons, but felt better after she used ARVs. Importantly, she was no longer allergic to any brands of tampons after she decided to use ARVs. This represents a tactic used by the nurse to make her patient feel secure regarding the efficacy of ARVs.

It is important to show that the same nurse does not follow up on the aspect of scepticism that she did pursue with another patient in case no. 6. In case no.6, the nurse pursued her scepticism on whether the patient had revealed her infection to her husband before the patient was permitted to take drugs. In the current case, the nurse does not need to do so because she knows this patient's medical history well. The patient in this case and her husband previously came to talk to the nurse regarding a successful abortion. Thus, it is not necessary for the nurse to ask whether this patient has revealed her infection to her husband or not. After the nurse persuades her patient, the nurse has to reassure the patient regarding the revelation of infection. The nurse wishes to render her patient secure about infection by finding a way to make an appointment confidentially.

5.22 [13 – 16:00] [VIDEO]

1. Nurse: if suppose I have got enough
 2. patients ((opening book) I will
 3. make an appointment for blood
 4. test
 5. Patient: right ((nodding)) (2.0) it will
 6. be a letter or anything else
 7. Nurse: I will send a letter that's
 8. better ↑right ((tossing head))
 9. Patient: ((tossing head))
 10. Nurse: → says that I will not tell anything

11. → ((waving hand)) tell only
 12. ((pointing)) the doctor makes an
 13. appointment suppose Monday 10 of
 14. March at 9.00 a.m. that's enough
 15. that's it
 16. Patient: → and at public health office also
 17. → will not tell
 18. Nurse: uh::: which prefer (3.0) because
 19. at public health office I have
 20. not told at all (.) not spoken
 21. Patient: right ((nodding))
 22. Nurse: → but some staff of hospital also
 23. → know but they do not say like
 24. → (3.0) >this person is< no
 25. Patient: ((nodding))
 26. Nurse: but they will note the history
 27. Patient: ((tossing head))
 28. (1.0)
 29. Nurse: that they do not ((shaking head))
 30. talk about this confidentiality
 31. Patient: ((nodding))
 32. Nurse: like we talk today ((moving hand))
 33. like mundane talk they think that
 34. we have normal talk
 35. Patient: ((nodding))
 36. Nurse: when finish talking (.) we do not
 37. talk about it somewhere else
 38. Patient: ((nodding))
 39. Nurse: we will stop ((quickly dropping a
 40. hand down)) in this room if meet
 41. outside afraid will worry (.)
 42. meet at the market (.) if meet
 43. in front of the hospital
 44. ((stretching hand)) will normally
 45. talk (.) do not worry no doctor
 46. (the nurse's name)) do not talk
 47. about it (.) do not worry about
 48. → this ((---tapping the patient's
 49. → leg 6 times---))⁶⁸ confidentiality
 50. is always confidentiality we agree
 51. → (.) this ((touching the patient's
 52. → leg))
 53. Patient: right

The above excerpt shows that the nurse attempts to find an appropriate way to make an appointment with the patient. The data show that the nurse helps her patient hide infection. The nurse refers to using letters as a way to contact each other, and writing only neutral messages in those letters. The nurse says that the letter will read that the patient is told to see the doctor on a specific date, month

⁶⁸ The symbol ((---tapping the patient's leg 6 times---)) means the speaker is producing an action as shown in double parentheses. At this point the nurse is continuously tapping the patient's leg six times (see details of transcription conventions in Appendix A).

and year, and there will be nothing else mentioned in the letter. However, the patient is still concerned about revelation of infection. She shows her worries in the next turn where she asks her counsellor whether the hospital will not inform public health staff in the district, stating ‘and at public health office also will not tell’ shown in lines 16-17. The patient asked for reassurance that her status would not be revealed, and the nurse went on to say how she would behave if they met in public. The nurse elaborates that she will not tell staff at the district public health office, but that there are some staff over there who should know. The nurse tells the patient that staff at the district public health office should keep the patient’s infection confidential. The way in which the nurse reassures her patient is to use a tactic of dramatisation, and greater stress at the end of her turn. The nurse produces some utterances quicker than other utterances when stating ‘but some staff of hospital also know but they do not say like (3.0) >this person is< no’ as shown in lines 22-24. In addition, in the last turn the nurse produces utterances in order to make her patient secure and less stressed regarding disclosure of infection. At this point, the nurse uses gestures. The nurse repeatedly and continuously taps the patient’s leg six times, as shown in lines 48-49. In lines 51-52, the nurse also touches the patient’s leg to reassure the patient.

The next example shows a patient of different social status and how this affects concerns about his infection. At the same time, the example shows the counsellor reassures her patient regarding infection and revelation of his blood test result. The first excerpt shows the nurse brings the topic of ARVs into discussion.

5.23 [35 – 26:08] [VIDEO]
[The patient was a monk. He wished to participate in the ARV programme.]

- | | | | |
|-----|----------|---|--|
| 1. | Nurse: | → | then ((looking straight))(2.0) |
| 2. | | → | nowadays there are ((looking at |
| 3. | | → | the patient)) antiretrovirals for |
| 4. | | → | taking in order to hold or delay:: |
| 5. | | → | to make this disease |
| 6. | Patient: | | ((twitching fingers)) |
| 7. | Nurse: | | slow (.) |
| 8. | Patient: | | ((twitching fingers)) |
| 9. | Nurse: | | such taking those antiretrovirals |
| 10. | Patient: | | Buddha blesses you ⁶⁹ ((twitching |
| 11. | | | fingers)) |

⁶⁹ In the Thai original is เจริญพร .

12. Nurse: about them (.) what do you think?
 13. ((staring at the patient))
 14. ((slightly moving body))
 15. Patient: if ((twitching fingers)) you help
 16. regarding drugs (5.0) will take
 17. as you told

The above excerpt illustrates an entry to the topic of antiretroviral drugs as introduced by the nurse. In lines 1-5, the nurse introduces the use and benefits of ARVs in stating 'then ((looking straight)) (2.0) nowadays there are ((looking at the patient)) antiretrovirals for taking in order to hold or delay::to make this disease'. She told her patient how the drugs work. The nurse clarifies with the patient that drugs work against the virus which causes AIDS, but only as far as slowing down the production of virus. At the end of sequences and the next sequences, the nurse asks the patient about his decision on ARVs.

5.24 [35 – 30:06] [VIDEO]

1. Nurse: what do you think about these
 2. antiretrovirals ((moving
 3. → forwards)) have you decided to
 4. → take or not to take or anything?
 5. (3.0)
 6. Patient: If take ((moving finger)) but
 7. have to pay (.) I⁷⁰ will not (.)
 8. → If take (.) will live longer
 9. → prolong life or-
 10. Nurse: orr:: mostly as I have seen (.)
 11. there are many patients taking
 12. ((moving hands))
 13. Patient: Buddha blesses you
 14. Nurse: about (2.0) 50 about 50 right
 15. Patient: right.
 16. Nurse: ((looking straight)) saw them
 17. healthier right (.) good looking
 18. Patient: ((slightly nodding))
 19. Nurse: → feel that nice skin (.) healthier
 20. → (2.0) importantly (.) it ((looking
 21. → down)) also depends on how they
 22. → look after themselves ((nodding))
 23. Patient: Buddha blesses you
 24. Nurse: I think that (2.2) ((looking
 25. straight)) if Than Jao take (1.0)
 26. take ((smiling)) (2.0) what do
 27. you think ask (.) one more time
 28. ((smiling))
 29. Patient: → take ⁷¹((slightly nodding))

⁷⁰ The word 'I' used by this patient represents his higher status. This word is only used by people in monkhood when they address themselves to other who are monks.

The preceding excerpt shows that the nurse asks whether the patient wishes to take antiretroviral drugs or not as shown in lines 3-4. The patient shows that he has worries about the expense of the treatment. However, the data show that he felt the need to take drugs. At this point he shows an account as to why he thinks it is worth taking drugs. He told the nurse that he could prolong his life through treatment with ARVs as shown in lines 8-9. In these sequences, the nurse continues to encourage her patient to take drugs. The nurse refers to other patients who have already participated in a project. Those patients became healthier and began to look normal with nice skin in line 19. However, the nurse stresses in lines 20-22 that their better conditions were also dependent on how they looked after themselves. At the end of this excerpt, the nurse asks another time whether the patient would like to take these drugs or not. The patient has made his own decision in that he wishes to take them. The patient agrees to do so in stating that he wants to take them and he slightly nods in the same turn as shown in line 29. In the next excerpt, the nurse starts pursuing scepticism on whether the patient has already revealed his infection to anyone close so far. This action is important if the patient needs to take ARVs. Similarly, as shown in the preceding case no.06, the patient must find someone close to be his witness and carer in case he has an allergic reaction or experiences side effects from taking these drugs.

5.25 [35 – 38:41] [VIDEO]

- | | | |
|-----|----------|-----------------------------------|
| 1. | Nurse: | at first::: Than Jao did not want |
| 2. | | (1.0) father |
| 3. | Patient: | ((twitching fingers)) |
| 4. | Nurse: | mother to know ((nodding)) |
| 5. | Patient: | ((nodding)) ((twitching fingers)) |
| 6. | | uh |
| 7. | Nurse: | have you got (.) any brothers (.) |
| 8. | | sisters (.) have Than Jao got? |
| 9. | Patient: | (nodding)) about (.) there are |
| 10. | | seven |
| 11. | Nurse: | seven |
| 12. | Patient: | ((looking side)) ((smiling)) |

⁷¹ The way in which the patient responds to the nurse's question represents a linguistic matter. When the speaker answers or asks the questions, a main verb will be used. The auxiliary verb is not used. This is different from English. In English, when one asks the question whether you want to go or not, if the speaker wants to go, he or she will answer 'I do', but in Thai, the speaker will answer 'I go' instead. However, I sometimes use an auxiliary verb to make the transcript make sense for non-Thai native speakers.

13. ((counting)) (3.0) parents have
14. got a lot of children (5.0)
15. ((slightly nodding)) seven

In the preceding sequences, the nurse probes further about the family of the patient. The nurse wishes to know whether the patient has anyone to whom he can turn. The nurse starts off by asking whether the patient did not want his parents to know about his infection. Then the nurse probes further as to whether the patient has any brothers or sisters. The patient told the nurse that he had seven siblings. When the nurse is provided with information on the number of brothers and sisters in the family, the nurse probes as to whether there is anyone particular to whom the patient feels closest, as shown in the next sequences. This action conducted by the nurse is to allude to how far the patient reveals his infection to a third person.

5.26 [35 – 39:08] [VIDEO]

1. Nurse: seven right (2.0) Than Jao is
2. close (1.0) amongst these seven
3. → brothers sisters (.) [the closest
4. Patient: [((twitching
5. fingers))
6. Nurse: have got any ↑right ((raising
7. eyebrows))
8. Patient: there is elder brother ((twitching
9. fingers))
10. Nurse elder brother before-
11. (1.0)
12. Patient: before myself
13. Nurse: or:: (2.0) is before (.) Than Jao
14. Patient: ah ((nodding)) before me right (.)
15. I
16. Nurse: → have you:: trusted:: him much
17. (1.0) or how
18. Patient: he is the person who-
19. Nurse: have anything (.) talk to each
20. other
21. Patient: consult (.) he is a bit
22. knowledgeable (.) he is more
23. responsible than others
24. Nurse: and ((moving forwards)) personal
25. matters of Than Jao (.) have you
26. ever talked ((moving backwards))
27. to him on this ((nodding))
28. Patient: ah::: he has already known (.) he
29. listened to it
30. Nurse: or:: ((clasping hands together)
31. told him ↑already
32. Patient: told him already ((nodding))

33. Nurse: what did (.) tell him
34. Patient: → now (.)has known test result
35. → ((twitching fingers)) now has
36. → known blood test result
37. ((twitching fingers))
38. Nurse: uh:: what did he say ((relaxing))
39. Patient: he said (.) if have to buy
40. medicines ((slightly moving
41. legs)) all money may have gone
42. ((twitching fingers)) saved money
43. less than 10,000 baht right (.)
44. if I die first ((twitching
45. fingers)) that time the money
46. would not be enough for spending
47. ((showing hand)) on a funeral (.)
48. ah:: brothers and sisters (.)
49. each is quite poor
50. Nurse: right
51. Patient: they don't have like other people
52. (.) then (.) will save money
53. ((twitching fingers))
54. Nurse: ((nodding))
55. Patient: for my funeral after I died (.)
56. if government or (3.0) you will
57. help regarding drugs with no
58. charge (.) I would like to take
59. those drugs (.) will take them
60. (.) to take (.) at the monastery
61. ((twitching fingers))
62. Nurse: ((slightly nodding)) ((slightly
63. nodding)) ((slightly nodding))
64. (3.0) concludes (.) he can help
65. (1.0) you right ((smiling))
66. Patient: ah [((nodding))
67. Nurse: [can help regarding money
68. ((smiling))
69. Patient: also [((twitching fingers))
70. Nurse: [((moving legs)) nobody else
71. can help
72. Patient: ah::
73. (3.0)
74. Nurse: uh:: good (.) that's good (.)
75. have got someone close (.)
76. Patient: ((twitching fingers))
77. Nurse: have one (.) knows ↑right
78. ((tossing head))
79. Patient: ((nodding)) ((twitching fingers))
80. Nurse: → at least (.) if Than Jao (2.0) (.)
81. → there is anything happens right
82. → ((nodding))
83. Patient: uh ((nodding))
84. Nurse: → or become ill
85. Patient: ill
86. Nurse: → ill (.) he will know ↑right
87. ((tossing head))

The above excerpt shows that the nurse makes an attempt to find out whether the

patient reveals his infection to someone. The nurse is provided with information that the patient is close to one of his elder brothers. The patient told the nurse that he considerably trusted this elder brother as shown in line 16. This brother seems to be the patient's sole confidant at home. The patient normally talks over issues with this brother. This brother can support the patient regarding expenditure to some extent. Importantly, the patient told the nurse that this brother also knows the patient's blood test result as clearly shown in lines 34-36 stating 'now (.) has known test result ((twitching fingers)) now has known blood test result ((twitching fingers))'. At the end of the sequence, the nurse reassures him that the patient's brother should be the third person who will know if anything happens to the patient (lines 80-82). Furthermore, the patient's brother should look after the patient in case of illness or emergency as shown in lines 84 and 86. However, at this point, the nurse merely probes further in order to know whether the patient has already revealed his infection. The nurse does not inform the patient why she needs to know about a third person, as shown in the case no. 06. She does not mention a consent form, which must be signed by a third person. In this scenario, the nurse may be satisfied with the patient's reply that someone already knows of his infection. At the end of the conversation, at 01:08:00 minutes, the sequences of the conversation are from audio recording. This is because the video recording could not record beyond one hour. The nurse refocuses on the decision to take ARVs.

5.27 [35 – 1:08:00] [AUDIO]

- | | | | |
|-----|----------|---|----------------------------------|
| 1. | Nurse: | | have decided to take or not to |
| 2. | | | take? |
| 3. | Patient: | → | have decided to take (.) to |
| 4. | | | prolong life (.) a bit longer to |
| 5. | | | contribute society (.) because I |
| 6. | | | am still young (.) I can help |
| 7. | | | society if I can live longer |
| 8. | Nurse: | | Than Jao have got anything (.) |
| 9. | | | please call. |
| 10. | Patient: | → | ah:: Buddha blesses you |

The nurse refocuses on the need to use drugs. She reformulates it by asking her patient whether he prefers to take ARVs or not. The patient told his counsellor that he wishes to take them in line 3. He has given accounts regarding the use of

those drugs and why he was sufficiently worthy of taking those drugs. He downgrades the severity of AIDS and death by replacing it with the effect of antiretroviral drugs. He stated that he was still young and his life should be prolonged. If he took ARVs, he could stay a bit longer, and he would then be contributive to social missions. At the end of the conversation, the nurse closes the health talk by inviting her patient to contact her. She tells her patient to feel free to call her anytime when the patient needs more information relevant to health care. The patient uses a particular greeting in addressing the nurse throughout the conversation. In his last turn, he uses it another time to close the conversation in stating 'ah::Buddha blesses you' in line 10. This kind of utterance shows clearly the superior status of the patient is strictly adopted. It is not normally used amongst Thai people. People who are able to use such utterances must be ordained. Different language use can represent different social status in Thai society. This action can be seen in the sense that the patient is holding a superior status to that of the nurse.

So far, I have shown that patients play an active role in the context of ARVs. It is clear that patients pose many questions and propose possibilities in order to make themselves feel secure. In addition, they make an attempt to do the best to eliminate any risk to themselves that may result from the association between disclosure and the need for taking ARVs. Their actions have been conducted through the organisation of interaction. In this section, to some extent, we have seen a pattern of communication on ARVs. The topic is opened up and developed further by discussing disclosure, and using persuasion and reassurance. In addition, we have also seen that the active role of patients in this chapter is different from patients' roles in the next data analysis chapters. In those chapters, patients are passive; they rarely initiate or ask questions or propose new possibilities for their ways of life. My data can illustrate how the patient avoids risk; patients make an attempt to negotiate seriously and to play a game with counsellors by using language, body language, emotion and feeling. Such uses, in a medical setting, demonstrate the real world of HIV patients and AIDS, which is much clearer and more profound than descriptive thought given to Thai researchers during in-depth interviews, which is the more common form of data in the Thai research community.

In talking about ARVs, the nurse has to provide her patient with information about the health benefits and risk of taking ARVs. In the next section, I illustrate the way in which the counsellor delivers information to clarify with patients the benefits and risks of taking ARVs.

5.7 Information delivery

In delivering information on ARVs, the nurse has two main areas to cover. First, the nurse has to clarify the health benefits from taking ARVs. Second, the nurse has to inform her patient about the risks associated with taking ARVs.

5.7.1 Health benefits

The nurse always starts discussion of ARVs by showing a positive note. She explains to her patient that ARVs work against the virus, which can make the patient healthier. Here, it is important to reiterate that all counsellors are aware that ARVs are not cures; they merely slow down the production of the virus. Furthermore, taking ARVs may help the patient worry less about the physical symptoms of their illness as the disfigurement can be improved. In addition, the nurse convinces the patient by using a technique of referring to a third person who obviously became healthier and improved in appearance following treatment. The following example shows that the nurse makes an attempt to persuade her patient to join the programme by referring to better immunity and image.

5.28 [03 – 09:24] [VIDEO]⁷²
[The patient was infected by her ex-husband. She is living with a new husband who was still found to be HIV negative. She was not on the ARV programme.]

- | | | | |
|----|----------|---|----------------------------------|
| 1. | Nurse: | → | these ARVs will make ((moving |
| 2. | | → | hand)) immunity increase |
| 3. | Patient: | | ((nodding)) |
| 4. | Nurse: | | and decrease ((stretching hand)) |

⁷² During this health consultation, the patient was admitted to hospital. She came to talk with the counsellor in a wheel chair in a counselling room.

5. spots (.) image something like
6. that also ((nodding))
7. Patient: right

The above excerpt shows the nurse elaborating to her patient how she will become healthy after taking ARVs; these drugs will make the patient's immunity better as shown in lines 1-2. In addition, the nurse conducts information delivery by convincing the patient that spots and bad image can fade away. Spots, bad image, disfigurements, and weight loss concern most patients. The following example illustrates the nurse providing her patient with information about the health benefits from taking ARVs.

5.29 [38 – 33:15] [VIDEO]

[The counsellor was a midwife. The female patient was a widow. She was not on the ARV programme.]

1. Patient: → now who are taking?
2. Nurse: → ((nodding)) A LOT many people
3. Patient: uh those all low CD?
4. Nurse: uh ((nodding))
5. Patient: ((nodding))
6. Nurse: do you remember ((first
7. patient's name)) she looks fresh
8. (.) ((second patient's name))
9. she used ((pursing hand)) to be
10. skinny
11. Patient: ((nodding)) right
12. Nurse: ((name and sure name of another
13. patient))
14. Patient: ((nodding)) ((nodding)) can recall
15. Nurse: → now ((moving head)) is
16. → fresh looking (.) each is
17. → beautiful:::

In line 1, the patient asks the nurse about who are taking ARVs. The response to this question may help this patient decide about whether to take ARVs. In the nurse's turn, she told the patient that there were many patients taking ARVs. The way in which the nurse informed the patient is by using emphasis. In line 2, the nurse speaks to the patient with louder utterances and stresses it, stating '((nodding)) A LOT many people'. This action has been conducted to make the nurse's message important, and it can attract the audience's attention. The data show that the nurse is aware of a gender issue to some extent. She realizes that most female patients worry about their appearance. Consequently the nurse

provides her patient with information on how beautiful they can look by referring to other female patients. Those patients become beautiful after taking ARVs. The nurse refers to the third person as shown in lines 15-17, stating ‘now ((moving head)) is fresh looking (.) each is beautiful:::’. Referring to the healthy look of other patients is an important technique for convincing the patient to participate in this programme. After the patient is provided with information on the health benefits, unavoidably, they have to be informed about any risks which may occur from taking ARVs.

5.7.2 Risk associated with taking ARVs

It is no exaggeration to say that patients may experience side-effects, which this chapter considers to be a risk. Risk from taking ARVS ranges from minor allergic reactions to death. The patient is normally provided with information about risks they may encounter such as fever, vomiting, rash, diarrhea, and loss of appetite. Apart from the risks associated with ARVs themselves, the patient may put their life at risk from the process of taking ARVs. In the past, some patients forgot to take their ARVs as prescribed, and as a result treatment was not effective. Patients were told to take their ARVs regularly. In addition, some patients were illiterate, and had to remember the characteristics of each ARV rather than reading the indications on the label. However, patients have their own strategies to avoid risk. Some patients take their drugs according to an alarm clock. Some patients were reminded by other family members about when to take ARVs. The subsequent example shows that the nurse told the patient about the risks of taking ARVs. The nurse explains to the patient potential allergic symptoms.

5.30 [06 – 07:00] [VIDEO]
[The patient was married previously and is now living with her new husband and children. She wished to participate in the ARV programme.]

- | | | |
|----|----------|----------------------------------|
| 1. | Nurse: | you can't take them as you want |
| 2. | → | the reason is that (.) there |
| 3. | → | will be allergic symptoms and |
| 4. | → | there might be rash in the first |
| 5. | → | two weeks (.) one might be dizzy |
| 6. | | ((moving head)) so there must be |
| 7. | | someone to accompany here |
| 8. | Patient: | ((nodding)) right |

In lines 2-5, the nurse told the patient that the patient could not arbitrarily take ARVs because the patient may have side effects. The patient might be allergic to ARVs, and that may make the patient feel dizzy, or have a rash. Most nurses always inform their patients that they must stay at home for the first two weeks after initiating a course of ARVs because of the potential for allergic reactions. They should stay at home to keep an eye on what happens after taking them. In the next example, the nurse explains how the patient should take ARVs in order to make those drugs work efficiently.

5.31 [13 – 13:14] [VIDEO]

[The patient's husband was aware of the patient's infection. The patient and her husband previously discussed abortion with this nurse; this session was recorded on audio cassette. The patient still worries and this time, she came to see the nurse for ARVs; this session was recorded on video camera.]

- | | | |
|-----|----------|------------------------------------|
| 1. | Nurse: | ((looking down)) if you meet the |
| 2. | | criteria (.) will take |
| 3. | Patient: | ((nodding)) |
| 4. | Nurse: | but ((tidying documents up)) in |
| 5. | → | taking these drugs you have to |
| 6. | → | be exactly ((turning to patient)) |
| 7. | → | on time like a soldier |
| 8. | Patient: | ((nodding)) |
| 9. | Nurse: | → children going to school |
| 10. | Patient: | right |
| 11. | Nurse: | you have to take ((pointing)) one |
| 12. | | to another different 12 hours |
| 13. | | ((putting one hand on another)) |
| 14. | | suppose that today you choose to |
| 15. | | take 7 a.m. ((putting hand on the |
| 16. | | table)) 7 p.m. ((stretching hand)) |
| 17. | | you have to take them |
| 18. | Patient: | uh |
| 19. | Nurse: | if not on time at 7 p.m. treatment |
| 20. | | ((moving hand)) is not effective |
| 21. | | (.) there will be refractory |
| 22. | Patient: | ((nodding)) |
| 23. | Nurse: | because these drugs will control |
| 24. | | virus to some extent right |
| 25. | | ((sweeping hand)) |
| 26. | Patient: | right ((nodding)) |
| 27. | Nurse: | → if we take inconsistently |
| 28. | → | ((fluctuating hand)) the virus |
| 29. | → | will be ((fluctuating hand)) |
| 30. | → | decreased and increased |
| 31. | Patient: | ((nodding)) |

The above excerpt shows the nurse informing her patient how the patient should take ARVs. The nurse uses metaphor when she underlines the good discipline

required in taking ARVs. She states that the patient has to take drugs consistently. The patient must behave as if she were a soldier and a student going to school, as shown in lines 5-7, and 9. In addition, the nurse uses the modal verb ‘have to’ in most of her turns to stress that her advice should be taken seriously. Then the nurse explains that the drugs cannot work properly if the patient does not take them consistently. Importantly, the nurse elaborates on how the drugs can work efficiently if the patient takes them consistently. The nurse told the patient that the drugs will depress the production of virus. The way in which the nurse explains it is by using a sweeping hand. This action helps the patient understand what the nurse is telling her. The patient shows understanding by stating ‘right’ and nodding in her turn. In the next turn, the nurse explains further how the production of virus is slowed down by the drugs. In lines 27-30, the nurse states ‘if we take inconsistently ((fluctuating hand)) the virus will be ((fluctuating hand)) decreased and increased’. The use of a fluctuating hand represents the inconsistent work of antiretroviral drugs, and the virus will be occasionally active. The following example shows the patient’s risk experience from taking ARVs.

5.32 [41 – 07:26] [VIDEO]

[The counsellor was a midwife. The patient was a widow, and a single mother. She was on the ARV programme.]

- | | | | |
|----|----------|---|------------------------------|
| 1. | Nurse: | | what was (it) like last time |
| 2. | Patient: | → | felt dizzy |
| 3. | Nurse: | | ((nodding)) |
| 4. | Patient: | → | fever |
| 5. | Nurse: | | ((nodding)) |
| 6. | Patient: | | vomited (.) pain at legs |

In line 2, the patient told the nurse that she felt dizzy after she had taken ARVs. In addition, there were other symptoms from taking these ARVs. In line 4, the patient also had fever, and she vomited. She also had pains in her legs. These were found in some patients who were allergic to ARVs during the early period of ARV drug use. The following example shows the strategy which the patient uses to avoid risk.

5.33 [25 – 19:55] [VIDEO]

[The counsellor was a health educator. The patient was a male homosexual aged

50. *He was on the ARV programme.]*

1. Patient: I have taken them on time (.) oh
2. ((pointing)) ((looking up)) set
3. clock at 08.00
4. Nurse: that's good

The excerpt shows that the patient has his own technique to avoid risk. He sets an alarm clock to remind him when to take his medicines. However, although this patient takes ARVs according to an alarm clock to avoid risk, the ethnographic data show that this same patient finds difficulties in taking these drugs because he was illiterate. He told the researcher that he had difficulties and greater risk in taking drugs because he could not read the instructions he needed to follow the labels of medicines. He revealed that he had to remember the colour of each label and other characteristics of the medicines. During data collection, this patient could not sign a consent form for video recording. Instead, he stamped his fingerprint on a consent form.

The data show that ARVs seem to provide an opportunity to transform HIV/AIDS from a fatal disease into a chronic and manageable disease. Importantly, these drugs enable patients to have longer life spans. If patients take ARVs, they should not be at risk of opportunistic infection. However, patients may have terrible side-effects.

5.8 Conclusion

The nurses initiate the topic by responding to an inquiry of a patient, they persuade the patients to participate in the programme, and follow up some patients for reactions to drugs. The patients initiate it to request permission to take ARVs and to respond to statements made by nurses. It is striking that patients seem to be more active because in nearly twenty five percent of cases patients initiate the topic. While patients may wish to get the benefits from taking ARVs, they may encounter dilemmas and risk. Patients were told to find someone to be a witness to sign a consent form. This means that patients have to reveal infection to someone close. This makes patients hesitate to participate in the

programme if they do not want to let other people know their blood test results. However, the nurse still encourages the patient to participate in the programme. The nurse tries to find an appropriate way to conceal the patient's infection. During counselling, the nurse clarifies the health benefits from taking ARVs. At the same time the patient may be put at risk due to allergic reactions from taking ARVs. Patients must strictly follow the advice of the nurses. This chapter also illustrates two sides of risk taking. Patients may be at risk of opportunistic infections unless they take ARVs. However, they also put themselves at risk due to allergy, if they take ARVs without the necessary discipline. It can be said that most patients face a risk regardless of whether or not they are taking ARVs.

The next chapter will explore disclosure and confidentiality. Within it, four areas regarding disclosure and confidentiality will be shown.

Chapter Six

Disclosure and Confidentiality

6.1 Introduction

Whilst a number of studies have shown that fears of stigma, discrimination and marginalisation are a great concern amongst Thai patients in general, they show also that HIV patients experience less fear of stigmatisation. UNAIDS has supported the completion of six case studies on mobilizing family and community care for and by people with HIV/AIDS, entitled 'Comfort and Hope'. One of the case studies is the Sanpatong Home-based Care Project in Thailand (UNAIDS, 1999). This case study has shown that there was an increased feeling of openness amongst people living with HIV and less fear of stigmatisation. Dane (2002) examines the extent of disclosure and its effects on female Thai patients in three areas: children, family and friends. Although children experience the illness and death caused by AIDS in their fathers, mothers are reluctant to tell their children about their infection for fear of hurting them. They also fear rejection. In addition, Thai women living with a stigmatising illness exert an enormous effort to buffer their children from discrimination. This means that stigmatisation and discrimination is still an important matter in patients' concerns. This is an illumination of an aspect of disclosure and confidentiality of HIV/AIDS in the Thai context. Additionally, the report entitled 'AIDS Discrimination in Asia' by Asia Pacific Network of People Living with HIV/AIDS (2004, p.23) showed that discrimination still existed in many countries including Thailand. Friends and neighbours may discriminate against people living with HIV/AIDS if the infection is revealed, and the result of this could be exclusion from social functions. In my study, the data support the claim that maintaining confidentiality is still a major concern amongst Thai patients, and this is not just because patients fear stigmatisation and discrimination. In the counselling sessions, they discussed their experiences overtly. Discussion of stigma and discrimination has been underlined by the nurses more than once in some sessions. Patients have

techniques to render this topic one of high concern to the counsellor.

This chapter aims to cover four areas. First, as shown earlier, the threat of stigmatization affects the extent of disclosure and confidentiality. This relationship and the accountability of disclosure and confidentiality are illustrated. Second, the concerns and consequences of disclosure are demonstrated. In this section, I discuss the social consequences of disclosure, and to whom patients resist telling their infection and who should know their infection. Then I illustrate the way in which the topics of confidentiality and discrimination are identified as important and brought into discussion. Last, this chapter discusses why this topic needs to be addressed.

Patients have different reasons for maintaining confidentiality or disclosing infection. If patients do not want anybody to know of their infection, they resist telling other people, and this prevents them seeking HIV services such as counselling. UNAIDS (2000d, p.3) states that '[m]any people are afraid to seek HIV services because they fear stigma and discrimination from their families and community'. This means that patients make an attempt to hide their infection due to fear of stigmatisation and discrimination. Each patient has their own strategy to hide infection. For example, they may wear clothes such as hats, long sleeved shirts or trousers to hide physical signs of infection and full-blown AIDS. Some patients prefer staying at home to going outside. Patients need to reveal their infection to someone before participating in the programme of antiretroviral drug use, and this is possible for some patients. Some patients are not discriminated against and are accepted and welcomed in society, and so they feel it is positive to talk about their infection.

6.2 Exploring concerns and consequences

The interactional data show that confidentiality and discrimination is an important issue of concern for the patients; the topic must thus be addressed in the health consultation. The discussion extends beyond whether patients were discriminated against or how they were treated in their families and communities; concerns and consequences arising from the revelation of infection are discussed.

The way in which patients grapple with difficulties in the area of confidentiality and discrimination is also important.

6.2.1 Social consequences and disclosure

Revelation of infection leads a patient to unexpected crisis; a patient encounters discrimination, social isolation and stigma. The form of discrimination is related to hatred, blame or loss of outside contact. Some people in the community may not want to come into contact or associate with patients. The data show that some patients have been treated poorly while participating in mutual activities in villages or communities. For example, while participating in a funeral people would refuse to sit next to some patients. Some patients were told not to go to a hair salon because other customers were afraid of being infected. This makes patients socially isolated. Some patients have been identified as HIV transmitters, and as HIV is related to death, this is a stigma. Revelation of infection has also impacted on the running of a business for some patients. Additionally, children of infected parents, or infected children, were discriminated against at school. These examples illustrate the discrimination that exists in Thai society within the family, community, employment sector and educational institutions.

6.2.2 Patient's resistance

The data show patients are resistant to talking about disclosure and confidentiality. Their 'resistance' is apparent in two areas: first, patients resist discussing the matter of confidentiality, and second the patient resists telling other people of their infection.

Typically the counsellor probes indirectly to initiate discussion of confidentiality and discrimination. Some patients resist discussing these issues with the counsellor and produce a blocking answer. This does not discourage the counsellor from pursuing the topics. The probing typically continues with different forms of question and other linguistic techniques.

Second, the data clearly show that some patients resist telling other people of their infection. Patients are aware that their way of life might be affected if they let others know about their infection. They might encounter stigmatization

and discrimination, and they might be treated badly. Some patients feel comfortable disclosing their own infection, but feel uncomfortable talking about their children's infection. Thus they make an attempt to hide their own infection as well as their children's infection from other people. In giving up confidentiality, patients select who should know and who should not know of their infection. In many cases they will feel that they cannot reveal their infection to everyone. The types of people patients reveal their infection to can be categorised as family members, neighbours, colleagues and sexual partners. Confidentiality and discrimination are still matters of concern amongst Thai patients are deliberately covered in counselling sessions.

Family members: Patients might feel they need to conceal their infection in their own family because they are afraid of stigma. Some patients can not reveal their infection to their parents because their parents might be upset. Some female patients keep their infection secret from their husband. They might be stigmatised and deserted if their illness was revealed. Sometimes parents do not tell their own children that they have been infected with HIV from their mothers. As a result the parents have to keep knowledge of their own infection secret because they fear discrimination against their children either in villages or at school. Children belonging to parents living with HIV, or who have died of AIDS, may be discriminated against at school. Some patients are accepted within their family. All patients can assess whether and how far their own families are able to accept their illness. This is also addressed in sessions.

Neighbours: Patients might be discriminated against if they reveal their infection towards their neighbours in the community, and thus they may try to keep it confidential. Some parents maintain confidentiality to teachers in school because they fear discrimination against their children. In rural areas, patients and neighbours always share cultural traditions and ceremonies. As a result, patients might find it difficult to isolate themselves from their neighbours. However, some patients have not been discriminated against once knowledge of their infection is revealed. By contrast, they have been encouraged and supported by their neighbours.

Colleagues: Some patients do not want their colleagues to know of their infection because they might encounter stigma. In one of the case studies, the patient was a monk. He did not want his colleagues to know of his infection

because he was afraid of stigma and that he might be coerced to leave his monastery. Revelation of infection may lead to unemployment.

Sexual partners: Some patients felt unable to reveal their infection to their sexual partners because they might then not be able to continue their sexual affairs. In one health conversation, a patient informed the nurse about his sexual behaviours and the fact that condoms were sometimes used. This indicated that he did not always have safe sex. The nurse reminded him of his social responsibility, even though the patient did not report overtly that he felt superior when he was spreading or transmitting infections into other people. However, the patient was told by the nurse that his own infection might become worse if he did not have safe sex; he might himself be infected with different viruses if condoms were not used.

6.3 Who initiates talk about confidentiality?

My data show that overwhelmingly, nurses are the initiators of this topic. Only 2 of 43 patients initiated the topic during the video sessions; this seems to show that patients are passive. The following example shows the topic as initiated by a nurse.

6.1 [40 – 06:14] [VIDEO]

[The counsellor was a midwife. The patient was a widow. She was not on the ARV programme.]

- | | | |
|-----|----------|------------------------------------|
| 1. | Nurse: | and (.) have got any problems at |
| 2. | | school? |
| 3. | Patient: | no ((shaking head)) |
| 4. | Nurse: | no problem at school ((counting)) |
| 5. | | in community (.) in family have |
| 6. | | (they) discriminated against |
| 7. | | haven't they? |
| 8. | Patient: | no |
| 9. | Nurse: | against you ((moving hand)) |
| 10. | | against daughter ((moving hand)) |
| 11. | Patient: | °right° ((nodding)) |
| 12. | Nurse: | nothing at all (.) have they |
| 13. | | known that ((nodding)) you got |
| 14. | Patient: | ()((nodding))((looking at |
| 15. | | nurse)) |
| 16. | Nurse: | they said nothing ((shaking head)) |

17. Patient: °no° ((shaking head))
18. Nurse: parents ((moving hand)) brothers
19. sisters
20. Patient: ((shaking head)) nobody said.

The nurse in the above example wished to know whether the patient and her daughter were discriminated against in the community or at school. The data show that the nurse did not stop at her first attempt of addressing the topic, and she attempted to overcome her patient's resistance. The nurse applied different kinds of question to her turns of talk. The use of questions is one of the important topics in this chapter, and it will be addressed next. In this example it seems that the patient and her daughter were not discriminated against at all.

Patients initiating the topic of confidentiality and discrimination are also found in my data⁷³, though this is rare. The following example shows a patient initiating the topic. His infection was once suspected by neighbours, who were also customers at his sister's business. The patient told the nurse that he was afraid of stigmatisation in case it affected his sister's business.

6.2 [04 – 01:11] [VIDEO]

[The counsellor was a midwife. This patient was a male homosexual. He used to be involved with commercial sex work in Bangkok. He was not on the ARV programme. He helped his sister run a business. To some extent, his infection affects his business.]

1. Nurse: you can ((moving hand)) bring your
2. life to come to normal
3. Patient: ((nodding)) ((nodding)) but I
4. still worry (.) about my elder
5. sister if she tells me to
6. ((nodding)) [sell ((sniffing))
7. Nurse: er:: ((tossing head)
8. that day you told-
9. Patient: err:: ((stretching body))
10. Nurse: uh what's next?
11. Patient: my sister delivered stir fried
12. pork with some soups
13. Nurse: ((nodding))
14. Patient: then (.) customers who ordered
15. ((moving hand))
16. Nurse: ((nodding))
17. Patient: asked her that ((nodding)) whether

⁷³ The data show that two patients initiated the topic of confidentiality; they were a homosexual man in case no. 04 and a widow in case no. 41. In some sessions, counsellors maintained confidentiality by completing the session without mentioning the words 'AIDS' or 'HIV', as happened in case no. 05.

18. (0.2) younger brother got AIDS or
 19. ↓not (.) got AIDS ((nodding))
 20. ↑right
 21. Nurse: ((nodding)) ((nodding))
 22. Patient: my sister err:: (0.1) told that
 23. he was (.) but did not help in
 24. any way
 25. Nurse: ((nodding)) ((nodding))
 26. (0.3)
 27. Patient: ((sniffing)) fortunately the
 28. customers understood

The example above illustrates how the topic was brought directly into the discussion by the patient himself. The patient worried that his infection might affect his sister's business. His sister was asked by customers whether the patient had AIDS. However, the patient told the nurse that his infection did not make the business sluggish because the customers believed his sister when she told them that the patient did not involve himself with the business. The data show that patients who run a catering business were more likely to be discriminated against by customers refusing their products.

Here, I show how the topic initiator approaches talk about confidentiality. This study does not aim to show how the patient initiates the topic because in most sessions, the topic is initiated by the nurse. Consequently, we show how counsellors bring the problematic issue of patient's concerns into discussion

6.4 Counsellor's techniques in talking about confidentiality

The data show that talk on confidentiality and discrimination is sensitive in the Thai context. Thus, the first attempt to address the patient's confidentiality is indirect. Counsellors normally begin by using an indirect question about the patient's family or other people in the community.

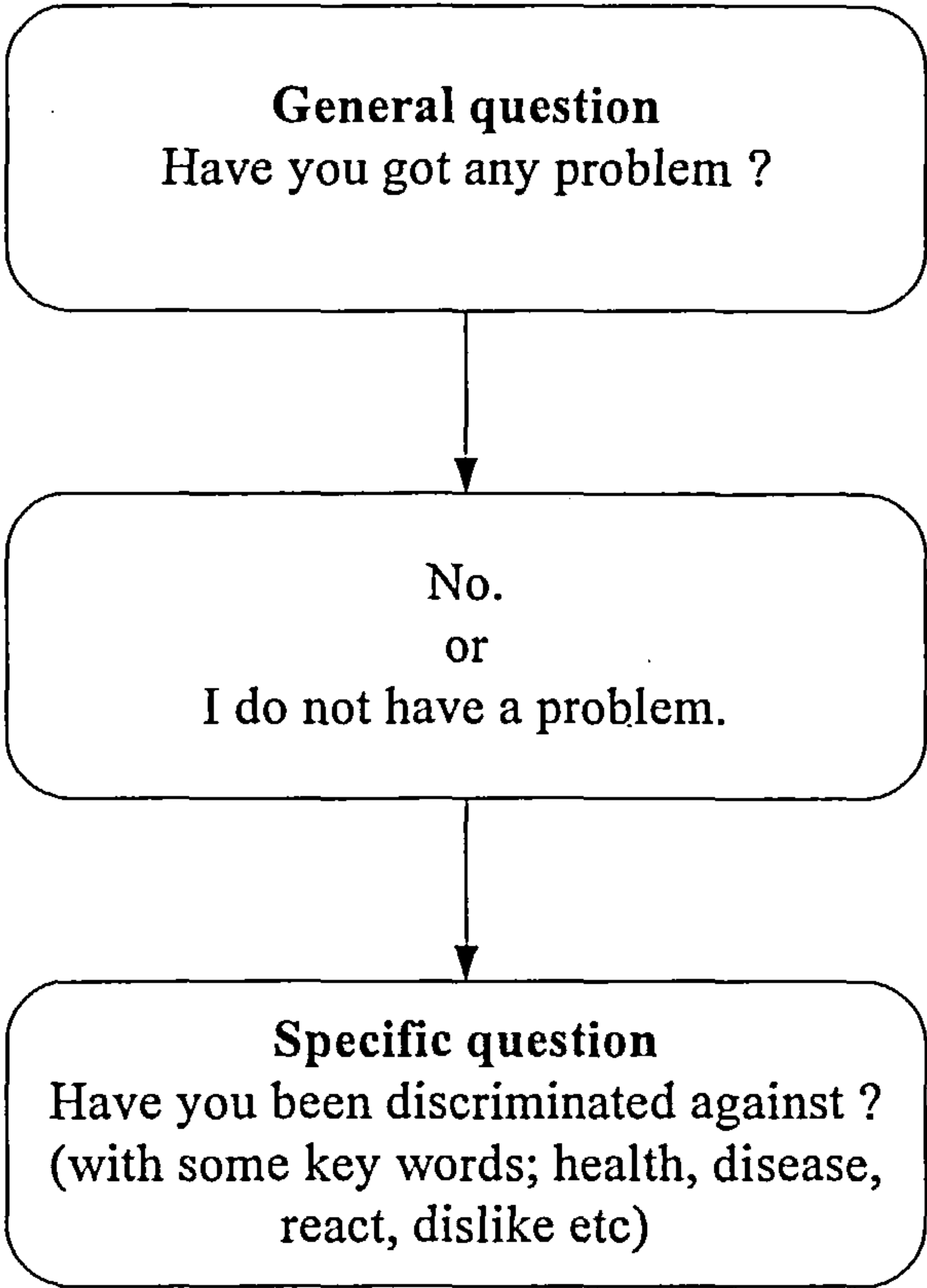
I demonstrate what marks the topic out as sensitive in a discussion. The data show that the topic does not enter the discussion abruptly, but is instead introduced by using oblique techniques. The nurse first uses a general question, and then moves on to a specific question. Alongside the use of such questions, the nurse uses gestures such as stretching her body and moving forwards before she starts a question. Sometimes, the nurse uses a preface such as 'em'. Micro

and Macro pauses are also used before the topic is initiated. Furthermore, the nurse may produce slower utterances compared to other structures of talk. This use of verbal and non verbal communication can help the nurse introduce the topic. Once the topic is successfully initiated, it is followed up directly and overtly.

6.4.1 General question and more specific question

The topic of confidentiality is addressed indirectly at first, so the nurse has to find an appropriate way to allude to it. Typically the nurse uses a general question, such as 'have you got any problem?'. At this stage, the nurse expects a response concerned with confidentiality and discrimination. However, the data show that patients typically do not respond with what the nurse wishes to know at the first question. In addition, the nurse sometimes encounters a blocking answer where, they get only 'yes' or 'no' responses from their patients or insufficient explanation. Consequently, the nurse moves to a more specific question such as 'has the patient or her son or daughter been discriminated against?'. The use of a more specific question helps the counsellor clarify what they need to know. The move from a general question into a specific question seems to be a stepwise fashion of talk (see Jefferson, 1984b). Following the specific question, patients can respond directly to the counsellor about confidentiality and discrimination. On some occasions, the counsellors use key words such as 'health', 'disease', 'react' or 'dislike' to make the response more specific. This can be seen in Diagram 6.

Diagram 6. The use of a general question and a specific question



The following examples are given to underpin what has been discussed about the use of general questions, specific questions and the use of key words. In the first case, the health educator wishes to know whether her patient has been discriminated against in her own community. She initiates a general question followed by a specific question.

6.3 [23 – 08:58] [VIDEO]

[The counsellor was a health educator. The patient was a widow, and a single mother. She was on the ARV programme.]

- | | | | |
|----|----------|---|-----------------------------------|
| 1. | Nurse: | → | ((stretching body)) em:: have you |
| 2. | | → | got any problems in village I |
| 3. | | → | mean- |
| 4. | Patient: | → | in village (.) no |
| 5. | Nurse: | → | whether they have discriminated |
| 6. | | → | against [you right? |
| 7. | Patient: | → | [no ((shaking head)) |
| 8. | Nurse: | | no |

At 08:58 minutes, the nurse starts the topic by applying a general question in lines 1-3 stating ‘((stretching body)) em:: have you got any problems in village I mean-’. The nurse initiates the topic using general statements because she is aware of the sensitivity of the topic. The nurse demonstrates the sensitivity by using body movement and stretching her body. In addition, the sensitivity of the topic can be seen from the use of preface ‘em’ in line 1. The patient responded by producing a short blocking answer ‘in village (.) no’ in line 4. The nurse then moves to another specific question, as shown in lines 5-6. The data seem to show that the patient was not discriminated against in the community. The patient confirmed this by stating ‘no’ and shaking her head in her final turn in line 7.

The subsequent example is unusual because the patient is a monk and therefore holds a higher status than the counsellor. The nurse initiates the topic of confidentiality. The patient responds to it by asking for co-operation from the counsellor to maintain confidentiality.

6.4 [35 – 17:05] [VIDEO]

[The patient was a monk. He wished to participate in the ARV programme.]

- | | | |
|-----|----------|---|
| 1. | Nurse: | right |
| 2. | | (8.0) |
| 3. | Patient: | → what else do doctor want to ask |
| 4. | | → ((moving fingers)) |
| 5. | Nurse | → Than Jao ⁷⁴ have:: anything else |
| 6. | | → ((moving forwards)) problems |
| 7. | | → ((moving backwards)) about living? |
| 8. | | → would like (.) living (.) how? |
| 9. | | → ((nodding)) |
| 10. | | (0.1) |
| 11. | Patient: | → I just go on living by making use |
| 12. | | → of the preaching of lord Buddha |
| 13. | | → (.) but I have been infected with |
| 14. | | → virus (.) (I) will try to be |
| 15. | | → healthy making use of Dharma (.) |
| 16. | | → if (.) we have got virus in my |
| 17. | | → body |
| 18. | Nurse: | ((moving hands up)) ((clasping |
| 19. | | hands together)) ((putting hands |
| 20. | | clasped on the table)) ((looking |
| 21. | | at patient)) |
| 22. | Patient: | it is good for one thing (.) that |
| 23. | | is (.) (I) will prepare |
| 24. | Nurse: | ((relaxing)) |
| 25. | Patient: | ourselves before death |

⁷⁴ Than Jao is linguistically pronounced /thâ:n-câ:w/ (see Naksakul, 1998). These utterances are used to address only this patient who holds the status of monkhood.

26. Nurse: ((slightly nodding))
 27. Patient: → uh (.) I have been infected (.) I
 28. → will take care (.) probably (.)
 29. → () will live for ten years
 30. → twenty years like doctor's
 31. → recommendation
 32. Nurse: ((slightly nodding))
 33. (0.1)
 34. Patient: (if) we do not know that we have
 35. been infected (.) we will be
 36. negligent () may drink or smoke
 37. (.) which brings destruction
 38. (8.2)
 39. Nurse: → right ((moving legs)) (2.0) uh in
 40. → your monastery when you found out
 41. → you were infected (.) have you
 42. → worried about confidentiality?(.)
 43. → or you worry that someone else
 44. → will know (3.0) ((slightly
 45. nodding)) or how about it
 46. Patient: quite worry (.) because the monk
 47. (.) people will normally invite to
 48. chant or preach (.) people always
 49. → respect if they know about
 50. → infection (.) they will
 51. → discriminate against (.) probably
 52. → (.) senior monks will
 53. → discriminate against (me) (.) they
 54. → are afraid that they might be
 55. → infected with it by me (.) they
 56. may force me to stop being a monk
 57. (.) that I need you to keep it
 58. confidential (.) the most
 59. secretive until second stage or
 60. (.) die because second stage is
 61. already worse (.) I do not want to
 62. disclose at the first stage (.) I
 63. → do not want anybody to know (.) my
 64. → parents will panic (.) because
 65. they are not well-educated they
 66. might be misinformed

At 17:05 minutes, in lines 5-9, the nurse produces utterances 'Than Jao have:: anything else ((moving forwards)) problems ((moving backwards)) about living? would like (.) living (.) how? ((nodding))'. These utterances are designed in order to address her patient about confidentiality. The nurse initiates the topic by using a general question to find out about confidentiality and discrimination. She seems unsuccessful because the patient does not respond with what she would like to know. The patient resists discussing about confidentiality and discrimination and instead told the nurse how he could go on living; he followed the preaching of the lord Buddha. In lines 11-17, the patient constructs sequences relevant to the

orientation of a Buddhist; he makes use of the preaching of the lord Buddha. In addition, he responds by addressing the issues of dread by stating he will prepare for death and if he looks after himself well, he might be able to live longer, as shown in lines 27-31. As the topic is sensitive, before the nurse asks the patient a question, she uses a body movement; she moves her body forwards and backwards as shown in lines 6-7. At this point, the patient did not respond directly that he was afraid of discrimination. The patient indicates that he fears discrimination by showing that he has tried to hide his infection from people, stating in lines 14-15 '(I) will try to be healthy...'. As the nurse was not provided with what she wished to know, she used a more specific question in lines 39-44, stating '...have you worried about confidentiality? (.) or you worry that someone else will know (3.0) ((slightly nodding)) or how about it'. The nurse uses three actions in line 39 that illustrate the sensitivity of the topic, she uses body movement in her legs, a pause (2.0), and a preface-'uh', before she started the specific question. On this sensitive topic, the use of a general question and then a specific question is an important tactic, as a direct approach is inappropriate. Finally, the patient told the nurse that he worried that other people would know about his infection.

As well as illustrating the matter of alluding to confidentiality, this excerpt illustrates two features of the patient's account for his secrecy. His explanation covers both his professional and personal life. For his personal life, the patient has used a strong formulation. In lines 63-64, the phrase, 'my parents will panic' is constructed in a dramatic fashion. In this sequence, the patient has used some strong words for emphasis. Instead of using a milder word such as 'upset', he has used the word 'panic' as a direct prediction of potential emotional consequences. The word 'panic' is a kind of strong formulation. The patient has used this strong formulation in order to emphasize that his infection has to be kept confidential and his illness cannot be revealed to his parents. He uses this to account for his actions to preserve the concealment of his illness. His explanation uses accounts which are constructed in a strong and upgrading fashion.

In addition, the patient has used a particular tactic by moving from hypotheses to actual situations. In lines 49-55, '...if they know about infection (.) they will discriminate against (.) probably (.) senior monks will discriminate against (me) (.) they are afraid that they might be infected with it by me...', the

patient claims that he was afraid that he would be discriminated against if his colleagues knew his infection. This is only his presumption and is not based on actual experience. This is a tactic used to strengthen his point by turning hypothetical consequences into reality he emphasises his need to keep his infection confidential. In addition, the patient employs another technique of paradox in the following excerpt.

6.5 [35 – 21:45] [VIDEO]

- | | | |
|----|----------|---------------------------------|
| 1. | Patient: | I would like to- |
| 2. | Nurse: | publicity |
| 3. | Patient: | do more publicity towards other |
| 4. | | → patients (.) AIDS is still |
| 5. | | → related to discrimination |
| 6. | Nurse: | ((looking straight)) |

The patient has produced sequences that place him in a paradoxical position. The patient has been infected with HIV and he has noticed considerable discrimination. When he talked later about AIDS, he said that AIDS is still related to discrimination, in lines 4-5 and that he has tried to advise people in his community on the matter. This implies that he believes AIDS patients should be accepted in the same way as any other person in society.

In addition, his explanations can be analysed as a kind of balancing act. While he would like to keep infection confidential, he wants more openness about AIDS in general. The following excerpt shows this feature.

6.6 [35 – 24:12] [VIDEO]

- | | | |
|-----|----------|------------------------------------|
| 1. | Nurse: | Than Jao (.) you think that (.) |
| 2. | | ((smiling)) you can take good |
| 3. | | care of ↑yourself ((nodding)) |
| 4. | Patient: | ((slightly nodding)) (uh) in |
| 5. | | particular (0.1) mind |
| 6. | Patient: | mind |
| 7. | Nurse: | right (.) right (.) and you can |
| 8. | | contribute to others ↑right |
| 9. | Patient: | ((nodding)) |
| 10. | Nurse: | right ((smiling)) suppose |
| 11. | | ((stretching hands)) if in the |
| 12. | | second stage ↑right |
| 13. | Patient: | ((nodding)) second stage |
| 14. | Nurse: | you think that you will hide it or |
| 15. | | how will you do? |
| 16. | | (0.3) |

17. Patient: → for second stage (.) if
 18. → ((twitching fingers)) society
 19. → discriminates against (.) I will
 20. → wander (.) If society accepts
 21. → (.) I prefer being there (.)
 22. nowadays (.) if I am not
 23. imprudent (0.1) try to make
 24. merit all the time contribute to
 25. society when they need help (.)
 26. if we do not make merit (.) they
 27. will ignore when we died
 28. Nurse: ((nodding))
 29. Patient: in addition (.) I got AIDS also
 30. (.) they will discriminate against
 31. me more (.) the society still
 32. discriminates (.) do not be
 33. negligent (.) try to make merit
 34. all the time.

As shown, in lines 17-21, he stated that if his infection was not accepted in the community, he would wander. By contrast, if it was accepted, he preferred to stay. This can be regarded as another account for his secrecy found during social interaction between the counsellor and patient.

We have seen that the patient in case no. 35, who was a monk, resisted telling others of his infection due to fear of stigmatisation and discrimination. The data show that the patient did not want to put his life at risk. Although he wishes to participate in AZT, he refuses to let someone know of his infection. In this matter he shows his active role in asking for help from the medical staff in keeping his infection confidential. This scene confirms that stigmatisation and discrimination is still a great issue of concern amongst Thai patients.

The subsequent case shows the nurse uses a general question with a clue referring to the subject of confidentiality. The use of clues can help the patient to understand what the counsellor means. Thus, the patient responds with what the counsellor wishes to know. In this case, the talk occurs in the patient's home. The nurse visited the patient at home for a follow up visit. During this health talk in this non-formal setting, the topic of confidentiality was initiated by the nurse and they addressed the topic five times, some of which lasted for more than five minutes. Thus, the topic was sometimes reformulated. This patient did not worry much about her own infection, but she was afraid of letting others know of her son's infection. She does not put her son's way of life at risk; especially his life at school. The following

excerpt illustrates that the patient does not feel uncomfortable about letting others know about her infection.

6.7 [36 – 23:02] [VIDEO]

[The counselling was held at the patient's home. The patient was a widow, and single mother. She is living with a son; her son was infected. She had given up taking ARVs, but she has now restarted them.]

- | | | | |
|-----|----------|---|--|
| 1. | Nurse: | → | and problems about surroundings |
| 2. | | → | ((moving hand)) °how <u>neighbours</u> |
| 3. | | → | reacted° [in villages ? |
| 4. | Patient: | | [neighbours in villages |
| 5. | | | have not got ((shaking head)) |
| 6. | | | any problem |
| 7. | Nurse: | | uh:: |
| 8. | Patient: | | they have not got any problem (.) |
| 9. | | | they also encourage me |
| 10. | Nurse: | | uh |
| 11. | Patient: | | when they had traditional fairs |
| 12. | | | in villages I would go (.) they |
| 13. | | | did not say anything (.) |
| 14. | | | sometimes ((moving hand)) I |
| 15. | | | helped them serve drinks (.) |
| 16. | | | I did not ((shaking head)) see |
| 17. | | | them discriminating against me |
| 18. | Nurse: | | uh: |
| 19. | Patient: | | regarding this (.) I did not hear |
| 20. | | | anything |
| 21. | Nurse: | | did they know right? |
| 22. | Patient: | → | right ((nodding)) they knew I |
| 23. | | → | revealed it to them all I was |
| 24. | | → | not secretive |

The nurse initiates the topic by using a general question with a key word, ‘reacted’ in line 3. This helps the patient understand what the nurse wishes to know. In this turn, the nurse feels sensitive to the topic, and consequently, the nurse produces slower utterances when stating ‘°how neighbours reacted°’. The patient told the nurse that she has not had any problem in the village. The excerpt shows that the patient disclosed her infection to other people in her family and in the community. In addition, she elaborated to her counsellor that she was supported by other people, and was not discriminated against when she participated in social fairs or festivals. At the end of the sequence, she told the nurse that she did not keep her infection confidential as shown in lines 22-24.

Although the patient felt comfortable revealing her own infection to people, she resisted telling neighbours and her son’s friends about her son’s

infection because she fears discrimination against her son. The following excerpt shows the nurse alludes to confidentiality and discrimination concerning her son.

6.8 [36 – 25:16] [VIDEO]

- | | | | |
|-----|----------|---|-----------------------------------|
| 1. | Nurse: | → | and how about problem |
| 2. | | → | ((stretching body)) with son? |
| 3. | | → | ((clasping hands together)) how |
| 4. | | | about your son? |
| 5. | | | (0.2) |
| 6. | Patient: | | um:: |
| 7. | Nurse: | → | How far did neighbours know? |
| 8. | | | tell me |
| 9. | Patient: | | ((shaking head)) uh (.) did not |
| 10. | | | know at all ((nodding)) about son |
| 11. | Nurse: | | uh:: |
| 12. | Patient: | | but I hardly ((moving head)) |
| 13. | | | accepted it (.) previously afraid |
| 14. | | | that son would be ill (.) I did |
| 15. | | | think it further |

In lines 1-2, the nurse applies a general question to allude to the confidentiality of the patient's son in stating 'and how about problem ((stretching body)) with son?'. The nurse is again aware of the sensitivity, shown by stretching her body in line 2. The patient did not respond at the first question, so the nurse used a more specific question in line 7 stating 'How far did neighbours know? tell me'. The patient told the nurse that she herself did not know. However, the patient indicates that she made an attempt to keep her son's infection confidential because her son might be discriminated against in the community and at school. The following excerpt shows who knows and does not know of her son's infection.

6.9 [36 – 26:00] [VIDEO]

- | | | | |
|-----|----------|---|-----------------------------------|
| 1. | Nurse: | | uh:: what is going on? (.) just |
| 2. | | | tell me |
| 3. | Patient: | → | because I am hiding (.) afraid |
| 4. | | → | that they would know (.) apart |
| 5. | | → | from cousins (.) those (.) my two |
| 6. | | → | elder brothers |
| 7. | Nurse: | | uh (.) uh |
| 8. | Patient: | | then nobody ((shaking head)) else |
| 9. | | | knows |
| 10. | Nurse: | | ((moving legs)) uh |
| 11. | Patient: | → | I will not let anybody know as I |
| 12. | | → | am afraid of only one thing |
| 13. | | → | ((moving hand)) °their friends |

14. → will discriminate against him°
 15. → ((looking down)) nowadays I am
 16. → very carefully KEEPING
 17. [it confidential
 18. Nurse: [°how about [at school°?
 19. Patient: [at school ((shaking
 20. head)) do not know either (.)
 21. there was one day his teacher
 22. mentioned right
 23. Nurse: right
 24. Patient: teacher of class ((sniffing))
 25. Nurse: uh
 26. Patient: she was close to him and she knew
 27. that I was ill
 28. Nurse: uh (.) uh
 29. Patient: and visited (.) she asked (.)
 30. whether he had blood test I told
 31. her a LIE that he did (.) I dare
 32. telling you frankly (.) I was
 33. → afraid that she would reveal it
 34. → at school
 35. Nurse: ((nodding))
 36. Patient: that he has not a dad (.) but the
 37. teacher was kind ((moving hand))
 38. I TOOK:: it (.) to think (.) all
 39. night long (.) I thought that
 40. → one day if something happened to
 41. → my son (.) what should I do

In lines 3-6, the patient told the nurse that she resisted letting other people know of her son's infection, but had revealed it to her elder brothers. In lines 11-14, the patient told the nurse that she did not let anybody else know of her son's infection because his friends at school might discriminate against him, stating 'I will not let anybody know as I am afraid of only one thing ((moving hand)) ° their friends will discriminate against him°...'. The data show that the patient feels uncomfortable talking about her son's infection. When talking about her son's infection, she shows strong emotion by placing great stress on the utterance 'KEEPING' in line 16. At the end of the sequence, the patient gives her accounts for why she has to keep her son's infection confidential, and why she could not let even the teachers know. This is because she was afraid that the teachers might reveal her son's infection (lines 33-34). She told the nurse that she worried about it so much that she kept thinking about it all night. She has presumed that revelation of her son's infection may lead to something unexpected occurring to her son, as shown in lines 40-41. This case illustrates how the patient has selected who should know of her son's infection and who must not know.

The next example shows the nurse trying to find out whether, and how far, her patient has been discriminated against. As a result, the nurse employs a general question and a specific question with a key word to initiate the topic.

6.10 [27 – 06:27] [VIDEO]

[The patient was a 17 year old widow, and a single mother. She was living with her parents. She wished to participate in the ARV programme.]

- | | | | |
|-----|----------|---|-----------------------------------|
| 1. | Nurse: | → | Have you got any problem ((moving |
| 2. | | → | head)) (.) staying together? |
| 3. | Patient: | | within the home? ((scratching |
| 4. | | | face)) |
| 5. | Nurse: | | ((nodding)) |
| 6. | Patient: | | there is some ((smiling)) a |
| 7. | | | quarrel |
| 8. | Nurse: | | ((smiling)) ((nodding)) about |
| 9. | | | (0.1) ((pointing)) yourself (.) |
| 10. | | → | health ((stretching)) or disease |
| 11. | Patient: | | about (0.1) myself when did not |
| 12. | | | like me (.) (mum) would speak |
| 13. | Nurse: | | mum said about your matter |
| 14. | Patient: | | right ((nodding)) when she was |
| 15. | | | drunk (.) she spoke it out (.) I |
| 16. | | | am not blaming her. |
| 17. | Nurse: | | alright |
| 18. | Patient: | | my brothers and sisters have |
| 19. | | | already known. |
| 20. | Nurse: | | ((nodding)) |
| 21. | Patient: | | they did not tell (.) They are |
| 22. | | | concealing. |
| 23. | Nurse: | | ((clasping hands together)) |
| 24. | | | ((nodding)) but amongst brothers |
| 25. | | | and sisters all have known |
| 26. | Patient: | | right ((nodding)) already known |
| 27. | Nurse: | | How about neighbours? |
| 28. | Patient: | | all in villages (.) they have not |
| 29. | | | known yet ((shaking head)) |
| 30. | Nurse: | | ((nodding)) |
| 31. | Patient: | | we have known about it amongst us |
| 32. | | | and mum (.) nobody else knows. |
| 33. | Nurse: | | ((nodding)) |
| 34. | Patient: | | ((stretching body)) they are |
| 35. | | | afraid that when my son has grown |
| 36. | | | up (.) he would be ashamed |

The nurse initiated the topic by using a general question in lines 1 and 2, stating 'Have you got any problem ((moving hand)) (.) staying together?'. The patient's reply was not one the nurse expected; the patient mentioned the quarrel in the family. Thus, the nurse probed further by using another specific question containing the key words-health and disease, as shown in line 10. The patient

states that her mother revealed her infection when she was drunk, but other family members still kept her infection confidential. This is because they were afraid of discrimination against the patient's son in the future.

The subsequent example is case no. 01. The nurse brought the topic into discussion and wishes to know whether the patient's daughter was discriminated against at school.

6.11 [01 – 20:54] [VIDEO]

[The counsellor was a health educator. The patient was a widow, and a single mother. She is living with her daughter; her daughter was infected.]

- | | | | |
|-----|----------|---|----------------------------------|
| 1. | Nurse: | → | nowadays (.) has your daughter |
| 2. | | → | gone to ↑school? |
| 3. | Patient: | | right ((nodding)) at:: |
| 4. | Nurse: | | where |
| 5. | Patient: | | gone to child development centre |
| 6. | Nurse: | | centre |
| 7. | Patient: | | ((nodding)) |
| 8. | Nurse: | | and ((pointing)) have others or |
| 9. | | | young children ((shaking head)) |
| 10. | | → | dislike? |
| 11. | Patient: | → | err:: (0.2) I have not seen |
| 12. | Nurse: | | have they known? |
| 13. | Patient: | | ((nodding)) have known |
| 14. | Nurse: | → | nothing at all ↑right |
| 15. | Patient: | | right ((nodding)) |

The data show the nurse uses a general question with reference to going to school as shown in lines 1 and 2, stating 'nowadays (.) has your daughter gone to ↑school?'. The patient did not respond with anything related to discrimination at school in her next turn. Thus, the nurse moves into another specific question with a key word. 'Dislike' in line 10 is a key word which helps the nurse clarify what she means. In line 11, the patient stated that she did not see any discrimination against her daughter. The nurse probes still further by stating 'nothing at all ↑right' in line 14. The patient then confirmed that there was no discrimination against her daughter.

All the cases show that talk on confidentiality and discrimination is still sensitive, and the topic is one of great concern amongst Thai patients. Thus, it is difficult to initiate it directly. The counsellor has to find an appropriate tactic to bring the topic into discussion. The use of a general question followed by a specific question is thus efficient. Sometimes, counsellors use key words in a

specific question to obtain a more accurate response. In the context of HIV counselling, the meaning of neighbours, surroundings and friends are different. Neighbours, surroundings and friends do not act as general terms which can be directly intelligible by members of society. This is because these utterances have to be put in a specific context. In other words, these utterances can be interpreted into other meanings depending on the context. In the context of HIV counselling, they are a precise representation related to confidentiality and stigma. In this manner, words or utterances are constitutive of the social world according to the principle of reflexivity of CA's particular central idea.

Language is used in following up the topic, as well as in opening up the topic. In discussing the topic, hypothetical and repairing techniques, home visits and cultural aspects are also exploited for obtaining more information on confidentiality and discrimination.

6.4.2 Hypothetical technique

Nurses often use a technique of proposing a hypothetical situation to discuss patients' confidentiality. This type of question seems to be positive because it is used to help patients prepare for something in the future. The following excerpt shows the use of the hypothetical technique.

6.12 [03 – 10:51] [VIDEO]

[The patient was infected by her ex-husband. She is living with a new husband who was still found to be HIV negative. She was not on the ARV programme.]

- | | | |
|-----|----------|------------------------------------|
| 1. | Nurse: | ((nodding)) when (you) went to a |
| 2. | | village or something like that (.) |
| 3. | → | have (you) got any problems? |
| 4. | Patient: | ((shaking head)) nothing. |
| 5. | Nurse: | uh |
| 6. | Patient: | There were people (.) kind to me |
| 7. | | ((smiling)) |
| 8. | Nurse: | uh::: ((smiling)) |
| 9. | Patient: | someone gave these (.) ((smiling)) |
| 10. | | [those. |
| 11. | Nurse: | [seems (you) have been lucky (.) |
| 12. | | this might be uh ((nodding)) |
| 13. | | because of yourself too |
| 14. | Patient: | right |
| 15. | Nurse: | because you are talkative |
| 16. | Patient: | ((laughing)) |
| 17. | Nurse: | and at ease to talk with (.) so |

18.		they love and nice (to you) (.)
19.		have you been afraid ((moving
20.	→	hand)) if they knew (.) they
21.	→	would discriminate against?
22.	Patient:	right ((nodding)).

The data show that the nurse uses a general question in line 3, stating ‘...have (you) got any problems?’. The patient’s first response does not provide what the nurse needs. This seems to present a problem for the nurse. However, after the nurse and patient discussed how the patient was lucky, most people in her villages were generous towards her, the nurse still needs to know about discrimination. At the end of the sequence in lines 20-21, the nurse used a hypothetical question stating ‘...if they knew (.) they would discriminate against?’. The patient then revealed that she would be discriminated against, but her response is presumptuous.

6.4.3 Repairing technique

Nurses sometimes use a repairing technique in question and response in order to clarify what information is required. This kind of technique may be used particularly when the nurse thinks that the patient does not understand what it is the nurse expects to know. The advantage of this repairing technique can be shown in the following example.

6.13 [19 – 25:20] [VIDEO]

[The patient was a widow. She was on the ARV programme.]

1.	Nurse:	→	and ((stretching hand)) has your
2.		→	daughter got any problems at
3.		→	school? (.) °friends
4.		→	[discriminated against°
5.	Patient	→	[no (.) <u>but previously</u>
6.			((looking down)) at the beginning
7.			((touching the desk)) previously
8.			there was a problem (.) at that
9.			time (.) was that my daughter did
10.			not know (.) that I have been
11.			infected (.)
12.	Nurse:		((nodding))
13.	Patient:		because I did not tell her
14.			((looking down)) when she came
15.			back home
16.	Nurse:		((touching face))
17.	Patient:		his name was ADD said that my mum

18. had got AIDS (.) °soon (.) your
19. mum would die°

In lines 1-4, in the excerpt the counsellor uses a general question that contains a repairing technique at the end of the turn ‘° friends [discriminated against °’. It is apparent that the counsellor might have underestimated her patient’s understanding of the discussion. Thus she uses the repairing technique to clarify what it is she would like to obtain. However, in line 5, the patient produces her utterances overlapping with the prior turn of the counsellor. This indicates that the patient understands the counsellor’s question well. The patient thus provides her counsellor with information on what happened with her daughter at school. Repairing techniques are used in responses as well as questions. Some nurses exploit this technique to ensure the accuracy of any information produced by their patients. In this regard, one example can be shown.

6.14 [29 – 32:52] [VIDEO]

[The patient was a widow, and a single mother. She was not on the ARV programme.]

1.	Nurse:	He is mature (.) not ((shaking
2.		head)) in primary but secondary
3.		school (.) How about the
4.		youngest one? Did you ask him
5.		((moving hand)) whether his
6.		friends have known (.) that his
7.		mum has been infected (.) and
8.		his friends have humiliated
9.		him something like that
10.	Patient:	at school (.) nothing ((moving
11.		hand)) mostly teachers kept it
12.		confidential (.) they would not
13.		let (.) any student know
14.	Nurse:	((tossing head)) uh:::
15.	Patient:	because if they reveal (.) they
16.		would discriminate against (.) son
17.	Nurse:	uh:::
18.	Patient:	let only teachers know
19.	Nurse:	→ that means (.) for this issue (.)
20.		there is no problem right
21.	Patient:	no but ((looking up)) in my family
22.		(.) they all have known but they
23.		have never humiliated because I
24.		accept the truth (.) let it be
25.		if they said (.) talked to sons
26.		if anybody said (.) I would
27.		report teachers (.) should not
28.		make fun of this thing (.) if it

29.		happened to their parents (.) what
30.		would they feel
31.	Nurse:	uh

In lines 19-20, the nurse uses the phrase ‘that means (.) for this issue (.) there is no problem right’ to repair the prior turn of the patient, and in order to confirm that the patient has informed her correctly. In the prior turn, the patient reports that her sons were not discriminated against at school.

6.4.4 Could I visit you at home? : Normal requesting question paving the way to disclosure

‘Could I visit you at home?’ is one grammatical sentence which can be used to discover the extent to which patients have revealed their infection at home or in their communities. This sentence is not used for opening the topic, but for reformulating the topic. Why do nurses have to ask for permission from their patients? The data show that in the past, some patients’ infection was revealed to others by medical staff visiting them at home. This led neighbours to suspect or predict the patient’s circumstances from observing the uniforms of the medical staff, or from seeing ambulances parked in front of the house, and the fact that there was a dialogue between the patients and medical staff. In this area, it is important to emphasize that a home visit is sometimes important but not critical. Thus permission needs to be given by patients and is crucial for medical staff.

Mostly patients grant permission for home visits. By granting permission the patient provides information on confidentiality and discrimination, even though the purpose of the home visit is for another reason. The nurse can assume that the situation regarding confidentiality cannot be too bad if she is allowed to visit the patient at home. The patient might be able to handle any difficulties with confidentiality, or might be open to their family and possibly their community.

The following examples illustrate the use of this kind of utterance as another tactic for alluding to confidentiality. The patient gives the nurse permission to visit him at home. This indicates that confidentiality might not be a great concern for this patient. However, the patient has to be assured in certain matters before he offers his permission.

6.15 [37 – 26:37] [VIDEO]

[The counsellor was a midwife. The male patient was Laotian. He worked in Thailand. He was not on the ARV programme.]

1. Nurse: right (.) should talk today or
2. tomorrow
3. Patient: can do it ((nodding)) today
4. Nurse: do it today (.) so tomorrow
5. ((moving forwards)) could I (0.1)
6. get permission to visit tomorrow
7. Patient: right ((nodding))
8. Nurse: will
9. Patient: right ((nodding))
10. Nurse: visit at that house
11. Patient: → at that ↑house? ((pointing out))
12. Nurse: right (.) right
13. Patient: right ((nodding))
14. Nurse: right (.) I will ((counting))
15. explain.err:: have you told
16. Patient: ((scratching face))
17. Nurse: anyone else about this matter
18. (0.1) have your brothers sisters
19. known what kind of illness you
20. have
21. Patient: but (.) ((pointing)) ((moving
22. head)) my sister does not know yet
23. ((pointing)) >but those people
24. already know<

The patient did not immediately accept the request of the nurse for a home visit. In line 11, he clarifies which house he will be visited at. It is apparent in the next sequence that the nurse has enquired whether this home visit is possible in order to discover whether her patient has revealed his infection to his family members. This is because, in the prior turns, the nurse and the patient have discussed whether the patient could be sent to a hospice in the near future for his own sake. Before making such a move, the patient should reveal his infection to his family. The next example shows the nurse asking for permission from patients who were brother and sister. The female patient accompanied her elder brother to talk to the nurse as he was a new patient. The nurse wanted to know to what extent both patients kept their infection confidential. The nurse thus uses a question about home visiting.

6.16 [28 – 51:27] [VIDEO]

[The counsellor was a midwife. The patients were brother and sister; the younger sister was infected before her elder brother. Neither patient was on the ARV programme.]

1.	Nurse:	and (.) do not worry ((sweeping
2.		hand)) I will reveal to others
3.		what I talk to you
4.	Male patient:	((nodding)) ((nodding))
5.	Nurse:	and if you do not want me to
6.		visit at <u>home</u>
7.	Female patient:	((nodding))
8.	Nurse:	or (.) do not want friends to do
9.		greeting with
10.	Female patient:	((nodding))
11.	Nurse:	when (.) we have gone somewhere
12.		(.) please let me know I will
13.		tell them ((moving hand))
14.	Female patient:	right
15.	Male patient:	((nodding))
16.	Nurse:	→ and (.) last question (.)
17.		→ suppose I wish to visit at home
18.		→ (.) will it be convenient?
19.		(0.3)
20.	Female patient:	((looking at male patient))
21.		((nodding)) alright ((smiling))
22.	Male patient:	((slightly nodding))
23.	Nurse:	((touching breast)) for me
24.	Male patient:	(should be alright)
25.	Nurse:	most of the time (.) I do not
26.		(0.1) use a hospital car
27.	Male patient:	((nodding))
28.	Nurse:	if the weather is good (.) I will
29.		use a motorcycle
30.	Female patient:	((nodding))

The nurse assures both patients that she must keep their infection confidential. If they feel uncomfortable to be visited at home or to be greeted by other patients in the same group, they should let the nurse know this. The nurse will help them cope with such difficulties. However, the nurse asks again whether the patients feel comfortable with her visiting them at home in lines 16-18. The data seem to show that patients disclosed their infection to some extent. They did not give the nurse permission for a home visit in their first response. The female patient seems to hesitate because she kept silent and looked at her elder brother first before she agreed to it by nodding. Here, it is important to emphasise that as well as the sequences of talk that inform the counsellor about the patient's confidentiality, the counsellor is also informed by observing the use of gestures and gaze by the patient. The nurse then makes the patients feel secure about their confidentiality. She told them that she normally used a motorcycle and rarely used a hospital car. The use of a hospital car can make neighbours suspect patients' infection.

6.4.5 Cultural questions

Two typical questions associated with cultural aspects have been used frequently to allude to stigmatisation in the family and community. The first is whether patients are eating together with their family. The second one is whether the patient has been included in social activities such as weddings or funerals in their communities.

It is worth remarking on why the nurses have picked up on these cultural ways of life to merge in with counselling activities. One possible explanation is that in doing counselling, the nurses use a participation framework. The patients and counsellors are living in the same setting and have a mutual culture. Thus it is not beyond the nurses' perception to make use of 'cultural eating' and 'culturally social participation' as a mechanism for understanding a situation regarding confidentiality and discrimination. During the consultation, these two aspects are ingredients for developing particular questions to allude to confidentiality and stigmatisation of patients either at home or in communities.

The topic of eating together in the context of HIV counselling is different from that in other contexts. First, I will discuss how questions associated with cultural aspects have been used in the context of HIV counselling, and then I will clarify how the context of eating together can be related to confidentiality. These questions are not designed to instruct patients. Instead nurses make use of these questions to discover whether the patients have been discriminated against in their families or communities. In other words, nurses observe discrimination if their patients cannot eat together with others.

6.17 [10 – 20:35] [VIDEO]

[The patient was a drug user. He is divorced from his wife. His daughter lives with his wife. He is living with his parents. He was on the ARV programme.]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | | how about nowadays? ((pointing)) |
| 2. | Patient: | → | nowadays ((nodding)) ate at |
| 3. | | | different places right I ate alone |
| 4. | Nurse: | → | ((nodding)) ((nodding)) you have |
| 5. | | → | ((shaking head)) not felt upset |
| 6. | | → | (.) right |
| 7. | Patient: | | I have not been ((shaking head)) |
| 8. | | | upset well (.) my sister-in-law |
| 9. | | | cooked food (.) took ((showing |
| 10. | | | hand)) it up |

11.	Nurse:	(uh) ((nodding)) ((nodding))
12.	Patient:	shared me some (.) put in the
13.		bowls together with [spoons
14.	Nurse:	[this
15.		((leaning the chair)) ((counting))
16.		that do not feel
17.	Patient:	when I had finished
18.	Nurse:	((counting)) feel anything
19.	Patient:	I washed them up

In line 2, the patient's turn indicates how he eats alone at home. In the next turn, the nurse clearly tries to elicit how her patient feels about eating in such conditions. This can be seen in lines 4-6, which is the turn produced by the nurse. The patient told the nurse that he did not feel upset that his sister-in-law separated food and containers for his meal.

In the following excerpt, the nurse would like to know about the situation regarding discrimination of a female patient. She thus poses a question in the cultural context of eating in line 1.

6.18 [31 – 14:47] [VIDEO]

[This patient married a man who already had a wife. Her husband subsequently left her. She was on the ARV programme.]

1.	Nurse:	Have you eaten↑together nowadays?
2.	Patient:	→ (we) have eaten ((nodding))
3.		together
4.	Nurse:	uh (.) ((moving hands)) your mum
5.		((shaking head)) does not
6.		discriminate against
7.	Patient:	parents do not discriminate
8.		against
9.	Nurse:	↓but she ((moving hand)) has
10.		compassion for you
11.	Patient:	((nodding))
12.	Nurse:	thus she said so

The data show the patient still ate together with her family members as shown in line 2. The nurse confirmed that the patient was not discriminated against by her mother.

The term 'culturally social participation' also refers to wedding parties, funerals and fêtes. One question which has been used by nurses to understand confidentiality and discrimination is how the patient participates in social activities in their communities. This question might enable nurses to understand

how other people react to their patients. The following excerpt illustrates the association between a question on social participation and discrimination.

6.19 [32 – 10:43] [VIDEO]

[The counsellor was a psychologist. The patient was a widow; she was living with a son, who was diagnosed HIV positive. She was not on the ARV programme.]

- | | | |
|-----|----------|--------------------------------------|
| 1. | Nurse: | uh (.) uh (.) uh |
| 2. | Patient: | nobody ((shaking head)) |
| 3. | | discriminates against |
| 4. | Nurse: | uh ((nodding)) |
| 5. | Patient: | went to work (.) eat |
| 6. | Nurse: | → (you) went to help them at various |
| 7. | | → fêtes ↑right |
| 8. | Patient: | right ((nodding)) |
| 9. | Nurse: | (you) went to help them (.) but |
| 10. | | they did ((shaking head)) not |
| 11. | | → react ↑anything |
| 12. | Patient: | uh (.) nothing at all ((shaking |
| 13. | | head)) |

At the beginning of the sequence, the topic of discrimination is addressed. In lines 6-7, the counsellor ensures that her patient was not discriminated against when she participated in any fete or any social activities. The patient did not respond in the next turn so the counsellor asks the patient another time by using a key word 'react' in line 11. The patient then told the nurse that she was not discriminated against at all.

6.5 Patient resists telling others

After the topic is opened up, the counsellor may encourage the patient to reveal their infection if necessary. However, the patient may resist telling others if they fear discrimination. The following examples show discussion of confidentiality and the resistance of patients after the topic was opened up. The data show that patients do not want to let others know their infection. However, they were asked to reveal their infection to someone if they wished to participate in a programme of antiretroviral drug use involving AZT.

The first example is the monk; he is afraid of discrimination if he is

noticed contacting anyone in his area for the purpose of antiretroviral drug use. He shows resistance throughout a lengthy sequence of talk.

6.20 [35 – 31:33] [VIDEO]

[The patient was a monk. He wished to participate in the ARV programme.]

- | | | |
|-----|----------|------------------------------------|
| 1. | Nurse: | how ↑many quota will each district |
| 2. | | ((retracting hand)) (name of |
| 3. | | hospital) will get how many for |
| 4. | | different districts ((nodding)) |
| 5. | | ((moving body)) ((looking down)) |
| 6. | | you live in different district |
| 7. | Patient: | different district (name of |
| 8. | | district) ((nodding)) |
| 9. | Nurse: | (name of district) district |
| 10. | | ((smiling)) can not cross the |
| 11. | | area. |
| 12. | Patient: | um ((twitching fingers)) |
| 13. | Nurse: | in addition (.) it is different |
| 14. | | area (0.1) difficult |
| 15. | Patient: | ((nodding)) |
| 16. | Nurse: | travel far ((nodding)) ((nodding)) |
| 17. | | ((nodding)) |

The above excerpt shows that the patient worries about revealing his infection to others. The data show that drugs are allocated on the basis of a quota in each area. The patient wishes to form part of the quota for another area for fear of disclosure. However, the nurse told the patient that he could not cross to another area and that he has to form part of the quota based on his area. The nurse makes an attempt to convince him against such action by stating that if he moves to another area for the purpose of transferring to a different quota, he will have to spend much time travelling. In the next lengthy sequences, the patient shows his considerable worries and concerns about revealing his infection to other people. Thus he asked for co-operation from the counsellor to keep his infection confidential as shown in the previous chapter in excerpt # 5.16. The patient avoids revealing his infection with medical staff in the hospital where he is living. Consequently, he wishes to have services at the provincial hospital. The nurse will help him hide his infection by finding a strategy to keep his infection confidential. The next sequences still show the patient's concern about confidentiality.

6.21 [35 – 32:22] [VIDEO]

1. Patient: I need you to help (.) inform them
2. there for confidentiality
3. ((twitching fingers)) for the time
4. → being (.) this time ((moving
5. → legs)) communities still
6. → discriminate against
7. Nurse: right

The excerpt above shows the patient makes an attempt to convince his counsellor that what he requests is reasonable and sensible. At 32:22 minutes, the patient refers to discrimination in communities in lines 4-6. In the next sequences, the patient continues to provide an account for his resistance to telling others about his infection.

6.22 [35 – 32:32] [VIDEO]

1. Patient: in addition (.) they will dislike
2. a monk who got married
3. Nurse: ((moving hands)) ((relaxing body))
4. ((clasping hands together))
5. Patient: → if they knew that ((twitching
6. → fingers)) been in::fected
7. Nurse: ((slightly nodding))
8. Patient: they would have more and more or
9. double hatred ((moving hands))
10. Nurse: right
11. Patient: → this period of time ((twitching
12. → fingers)) if communities
13. discriminated against (0.2) I
14. could not be there and (0.5)
15. have to move to somewhere
16. Nurse: ((slightly nodding))
17. Patient: → which I have not known yet need
18. → you ((twitching fingers)) (0.2)
19. → help to keep it confidential at
20. → over there (name of hospital)
21. → hospital if can not get
22. → antiretroviral drugs at (name of
23. → provincial hospital) (.) please
24. → inform (name of hospital)
25. → hospital for confidentiality for
26. → the time being.
27. Nurse: right ((looking down)) want to
28. help for confidentiality.

At 32:32 minutes, the patient uses a hypothetical situation to strengthen his account. He states that people in communities would discriminate against him if they knew about his infection (lines 5-6). Furthermore, he attempts to predict the

sequences of events following the disclosure of his infection. He states that he could not stay in those same communities, and he would have to move to another place in lines 11-15. In lines 17-26, he again asks for assistance from the nurse in keeping his infection confidential unless he could share the quota at a hospital he did not belong to. The nurse then makes her patient feel secure by stating that hiding his infection is her concern. The next excerpt shows how the nurse makes her patient less worried about disclosure; the nurse finds a way to hide his infection.

6.23 [35 – 33:19] [VIDEO]

- | | | |
|-----|----------|------------------------------------|
| 1. | Nurse: | Than Jao can contact a person |
| 2. | | who (0.2) is taking in charge of |
| 3. | | antiretroviral drugs at (name of |
| 4. | | hospital) hospital right. |
| 5. | Patient: | Buddha [blesses you ((nodding)) |
| 6. | Nurse: | [I will cooperate in person |
| 7. | Patient: | that's fine |
| 8. | Nurse: | Then (0.5) I will send staff (.) |
| 9. | | go to see you at monastery [right. |
| 10. | Patient: | → [that's |
| 11. | | → alright ((nodding)) |

At 33:19 minutes, the nurse proposes that her patient could contact staff at the hospital whom the nurse would then contact in person. In the mean time, the nurse would send staff to see the patient at the monastery instead and the patient would not need to go to the hospital. The nurse's proposals make the patient feel secure and satisfied. The way in which the patient shows his satisfaction is by producing an overlap utterance in stating '[that's alright ((nodding))' in lines 10-11.

Another example shows resistance by a patient who did not want to let her husband know of her infection. The scene shows the conflict between the need for ARVs and disclosure. The patient came to talk with the counsellor because she wanted to take ARVs. During the session, the nurse explained to her the terms of regulation for the antiretroviral drugs programme. Before any patient can participate in the project, he or she has to sign a consent form in front of a witness, which they must sign together. At this stage, the nurse has to ask her patient who will sign the form as a witness, meaning that the patient must let someone know of her infection. The patient resists telling others about her

infection. During the nurse's turn she alludes to who knows and who does not know about this patient's infection.

6.24 [06 – 03:17] [VIDEO]

[The patient was married previously and is now living with her new husband and children. She wished to participate in the ARV programme.]

1. Nurse: → ↑but indeed (.) there will be some
2. → relatives to know this (I) do not
3. → know (name of the patient) (0.1)
4. → have got anybody (0.1) Have (you)
5. got any (.) look after? by now
6. husband came to stay with ↑you?
7. ((walking to sit))
8. Patient: now husband is staying at home
9. ((slightly nodding))
10. Nurse: ((sitting)) ah::have you told him
11. ((moving hand)) before you came
12. to the hospital? ((touching
13. hair)) ((putting documents on the
14. desk))
15. Patient: (I) did ((nodding))
16. Nurse: uh what ((moving hand)) did he
17. say?
18. ((arranging documents))
19. Patient: he said nothing.
20. Nurse: uh:: ((stopping arranging
21. documents))
22. >°but he knew ↑right?°<
23. Patient: husband has not found out yet
24. Nurse: husband has not found out yet
25. Patient: ((nodding))
26. Nurse: ((looking at the patient)) about
27. infection ↑right?
28. Patient: right ((nodding))
29. Nurse: ((slightly dropping a hand down))
30. until now (0.1) husband has not
31. known yet
32. Patient: °has not known yet° ((shaking
33. head))
34. (0.2)
35. Nurse: have not told ((shaking head))
36. him at all ↑right.
37. Patient: I did not tell him.
38. Nurse: [uh:::
39. Patient: → [because (.) if (.) (I) told him
40. → ((looking straight forward)) and
41. → he knew (.) that I got infected
42. → (.) he would not take care of me
43. → (.) and then he would leave me.

At 03:17 minutes, the nurse opens up the conversation by asking whether the patient has anyone to tell about her decision to take antiretroviral drugs in lines

1-4. The patient told the nurse that she did not tell her husband about her infection. The data show that the nurse has to ask the patient several times to make sure that her husband does not yet know about the patient's infection. At the end of the sequence, the patient gave her account for resisting telling her husband. She told the nurse that she was afraid of being left by her husband if he knew of her infection. At this point, the patient gave her account using a presumptive prediction, as shown in lines 39-43. The patient stated '[because (.) if (.) (I) told him ((looking straight forward)) and he knew (.) that I got infected (.) he would not take care of me (.) and then he would leave me']. This can be regarded as a linguistic technique to make her resistance of revelation of infection reasonable.

Throughout the sequences of talk, the patient worries about letting someone know about her infection. The following excerpt shows the patient's worries and resistance to telling her husband.

6.25 [06 – 18:40] [VIDEO]

- | | | | |
|----|----------|---|------------------------------------|
| 1. | Patient | → | right if (I) do not let ((moving |
| 2. | | → | hand)) them talk (.) but |
| 3. | | → | ((writing)) take them to him to |
| 4. | | → | sign (.) is it ((nodding)) |
| 5. | | → | ↑alright? |
| 6. | Nurse: | | uh (.) [that- |
| 7. | Patient: | → | [take them to sign |
| 8. | Nurse: | | It must be signed at the hospital. |

The patient would like to take drugs without telling her husband. Thus, the patient proposed some alternatives as resolutions. She asked the nurse whether she could choose not to tell her husband, and whether she could take documents to be signed elsewhere in lines 1-5. The way in which the patient shows her worries can be seen in her turn. In line 7, the patient repeated her prior turn in stating '[take them to sign'. These utterances overlapped with the nurse's turn as she has not let the nurse finish her turn. However, the nurse told the patient that documents must be signed at the hospital.

In summary, we have seen that patients resist telling other people because they do not want to confront something beyond their control in facing stigmatisation and discrimination from others. These examples tell us of the existence of fear, stigma, discrimination and marginalization in Thai society.

6.6 Nurses' concerns about confidentiality

Nurses have to perform a public health role in addition to their roles as counsellors. In performing their multiple roles, nurses shape the counselling; the nurse needs to know of matters which may concern her patient. Those matters are the reasons behind nurses bringing up the topic of confidentiality. The nurse then makes an attempt to discover how patients could manage their concerns. As well as finding out patient's concern, and how patients cope with these, nurses also gave patients appropriate advice to maintain necessary confidentiality.

6.6.1 Stigmatisation and discrimination following disclosure

Stigma and discrimination resulting from disclosure concerns counsellors. Counsellors need to be updated on what patients encounter after their infection is disclosed, and on whether patients can tackle any problem that stems from the disclosure. Patients themselves may deliberately disclose their infection, but in my data, disclosure also came about through third parties without the patient's consent. The physical signs of HIV status can be highly visible. They might emerge in the form of darkening of the skin, wounds, cancer, spots, purple marks and weight loss. Disclosure is possible by word of mouth, and some patients' infection was revealed to others by family members.

Patients provided their reasons for why they revealed their infection to the public. Some patients are accepted and welcomed in society, and so they feel positive talking about it. They typically reveal during health conversation that they hesitated to reveal their infection at first, and they had to weigh up what reaction they would likely get after revealing their infection. It appears that they preferred to reveal their status as they believed that they would become happier as a result. In addition, they felt it would allow them to conduct their activities freely, without the need to hide anything. At this point, some of them become HIV network leaders and coaches for new HIV patients. They could train fellow patients to deal with the consequences stemming from infection. These accounts about disclosure were given during some counselling sessions, and in in-depth interviews with the researcher. However, positive consequences from disclosure

are rare.

The subsequent example shows a patient who was discriminated against by her family when she disclosed her infection.

6.26 [15 – 15:18] [VIDEO]

[The counsellor was a midwife. The patient was a widow. She was not on the ARV programme.]

1. Patient: at that time ((moving forwards))
2. I considerably thought of it I
3. could not accept anything (.)
4. ((smiling))
5. Nurse: ((tossing head))
6. Patient: brothers and sisters also
7. discriminated against
8. Nurse: → (uh) ((tossing head)) >how did you
9. → know they discriminate<
10. Patient: → brothers (.) sisters right
11. → ((nodding)) relatives blamed me
12. Nurse: ((tossing head))
13. Patient: → said (.) (I) deserved it (5.0)
14. → they said (.) if ((looking up))
15. → I had not stayed with (name of
16. → husband) (.) I would not have been
17. → like this

At the beginning of the excerpt, the patient mentioned that she had difficulty accepting her infection, and she told the nurse that she was discriminated against in her family. The nurse appraised the information her patient provided and then used the question '>how did you know they discriminate<' in lines 8-9. In the next turns, the nurse is provided with more information regarding the confidentiality of the patient in lines 10-11 and 13-17, specifically that the patient was blamed by her family members and told that she deserved to have AIDS.

In the following case, the nurse wishes to know what happened to a patient with schizophrenia, after he himself revealed his infection to his sister.

6.27 [02 – 19:10] [VIDEO]

[The patient was diagnosed with schizophrenia. He was divorced from his wife. He was not on the ARV programme.]

1. Nurse: → ah (.) right (.) right but (you)
2. → told ((nodding)) ((nodding))
3. → younger sister (.) (you) have got
4. → AIDS ↑also?
5. Patient: °have also got AIDS°

6. Nurse: → what ((nodding)) does sister
7. → think?
8. Patient: sister said ((looking up)) let it
9. be (.) it happened already

In the example, in the prior turn, the nurse wishes to keep the patient's infection confidential. Thus she asked the patient what he told his sister because the nurse will give the same account when she talks to the patient's relative. The scene illustrates the nurse's efforts to help her patient. At the end of this sequence, the nurse clarified whether the patient has revealed the fact that he has AIDS to his family, and whether her patient has been discriminated against or not. She asks her patient whether he has revealed his status in lines 1-4. In lines 6-7, the nurse asks 'what ((nodding)) does sister think?' in order to know what happened after he revealed his infection. This question is also used for discussing confidentiality and discrimination. The patient told the nurse that his sister was accepting of his infection, stating 'sister said ((looking up)) let it be (.) it happened already'.

6.6.2 Well-being and children

Living with HIV leads to stigmatization and discrimination for many patients. Consequently, this is a concern for nurses, particularly when discussing the patient's wellbeing.

Most Thai female patients have a childcare role, in accordance with Thai social structure. Nurses, especially in rural areas are well aware of this gender issue, and this leads to nurses asking about the impact of discrimination on patients' children. Nurses need to know whether children whose parents are infected, or who themselves are infected, were discriminated against by their friends or teachers at school or at the child development center. Dane (2002) showed that women living with HIV are concerned about confidentiality because they fear discrimination against their children.

The following example shows the nurse asking about who revealed the infection of the patient's children, and whether the children were discriminated against or not.

6.28 [17 – 39:49] [VIDEO]

[The counsellor was a midwife. The patient was a widow, and a single mother.]

She was on the ARV programme. One of her children was infected.]

1. Nurse: ((moving backwards)) °uh° hhh
2. >and how did they know<
3. Patient: well um::(0.4) ((moving lip)) how
4. did they know ((looking up))
5. Nurse: that's why ((two hands holding a
6. pencil))
7. Patient: where did (.) they know
8. Nurse: ah: for example ((looking
9. forwards)) to be honest like my
10. [neighbours
11. Patient: [uh uh ((nodding)) told (.) told
12. Nurse: neighbours(.) neighbours
13. Patient: mostly (.) they would ask ((moving
14. hands)) whether my son was
15. infected or not (0.2) like that
16. (.) well (0.4) (I) said ((moving
17. hand)) °infected° that's it
18. Nurse: ((looking forwards)) ((turning
19. immediately to the patient's
20. → face)) (0.5) have neighbours
21. → discriminated against?
22. Patient: to be honest for discrimination
23. Nurse: ((writing))
24. Patient: → they should discriminate against
25. → (.) (I) observed from (their)
26. → action ((moving forwards)) (0.3)
27. → sometimes they did not let
28. → their children play with
29. → suchlike
30. Nurse: ((nodding))
31. Patient: but it doesn't matter (.) I can
32. accept (.) but I would tell
33. ((stretching hand)) my children
34. Nurse: ((looking at patient))
35. Patient: please mind (.) when they played

In the example, at 39:49 minutes, the nurse asked who revealed the infection of the patient's children. The patient told the nurse that she herself told other people about her son's infection when she was asked. In lines 20-21, the nurse uses a specific question '...(0.5) have neighbours discriminated against?'. The patient elaborated in lines 24-29 that her children were discriminated against because neighbours did not let their children play with them. Whether children play together can reveal the extent of discrimination in a Thai context.

6.6.3 Problems and daily living

In sessions, the nurses wish to know how other people treat or react to their

patients. If the patient was discriminated against, the counsellor made an attempt to help the patient tackle or prevent the problem which could affect the patient's daily life.

Examples of how counsellors advised their patients to maintain necessary confidentiality can be shown. The patient in the first example was pregnant and decided to have an abortion, to which her HIV negative husband agreed. Counsellors gave the patient and her husband the advice to maintain confidentiality because the patient's husband obviously feared stigma and discrimination in a village. Although the main mode of data collection for this research was video recording, this case was recorded on audio cassette. This was necessary as the case was considered too sensitive to be recorded on video. The female patient freely admitted that she had got married and then divorced, but she did not know how she had been infected with HIV. This is because she had never had relations with anyone other than her husbands. Interestingly, her current husband was still HIV negative and he denied any infections, although he was sometimes away for work in the southern part of Thailand. The patient and her husband came to see a nurse at the first hospital on four occasions. The sessions were recorded by both audio and video recorder, the first three times being recorded on audio cassette. On those occasions a video recording was not permitted due to the presence of her husband. He did not want to be recorded by video because he was afraid of discrimination. However, for the fourth session, a video recording was possible because the female patient had agreed to it and attended alone. During the third consultation the sequences of conversation revealed that the female patient had taken two blood tests, and found she was infected. By contrast, her husband was found to be negative. They both came to talk to a nurse mainly about their decision to have an abortion. The female patient was ten weeks pregnant and she confirmed that she would like to have the pregnancy ended with the agreement of her husband. This difficult situation caused her husband to worry. Their worries and anxieties are clearly visible in the sequences of talk. They hesitated to decide to abort the pregnancy because they were afraid of stigmatisation in their communities, and they would like to keep the infection confidential. Before they took a decision about abortion, both of them had several questions which needed to be answered. They were concerned with the way in which the abortion would be conducted at that stage in the

patient's pregnancy; where the process of abortion would take place, whether set in a local hospital or a provincial hospital; how much risk the female patient faced; how they had to prepare for the abortion; how long they had to be admitted to hospital; and how much the female patient would suffer from an abortion. One classic concern was whether they would be able to continue social interaction with people in their communities smoothly. They were afraid that neighbours might suspect something if the female patient had to be admitted to hospital. In this case, two nurses worked in co-operation to find an appropriate resolution to the problem and advise their patients on how they should react socially to their neighbours. The nurse's advice can be seen in an excerpt from the conversation. The following excerpt covers discussion of the association between infection, abortion and the recommendations given by the nurses.

6.29 [01 – 10:18] [AUDIO]

[This session was recorded on audio cassette. Two nurses talked to the couple. The husband was still HIV negative, but the wife was HIV positive. They came to discuss a possible abortion with counsellors.]

1. Nurse 2: if hurt (.) (we) will inject for
2. sleeping (.) If have got curettage
3. Husband: → can I possibly refer to a cancer
4. amongst them (.) tomorrow?
5. Nurse 1: cancer ↑right?
6. Husband: right.
7. Nurse 2: If (you) refer to an haemorrhage
8. (.) that
9. Nurse 1: → haemorrhage
10. Nurse 2: → such accounts are more reasonable
11. Husband: well (0.2) I am afraid of
12. community outside I worry this
13. Nurse 2: if (you) refer to haemorrhage what
14. is the reason? If refer to
15. haemorrhage
16. Husband: I cannot enter village right (.)
17. my problem is [that
18. Nurse 2: → [if refer to
19. → haemorrhage (.) that for normal
20. → people (.) it is miscarriage
21. Nurse 1: miscarriage right
22. Nurse 2: → one has got haemorrhage (.) she
23. → can not be like that (.) can not
24. → (.) There must be a curettage
25. → applied as stated by a doctor (.)
26. → otherwise a patient will lose
27. → much blood then a curettage will
28. → be conducted (.) like abortion (.)
29. → I will tell (you)
30. Patient: hhh

31. Nurse 2: but whether (you) choose it or not
32. (.) depends on (you) as I have
33. been working in that room
34. Patient: uh
35. Nurse 2: as normal (.) there are some
36. patients with haemorrhage pregnant
37. [patients
38. Patient: [pregnant patients
39. Nurse 2: as:::normal
40. Husband: → we tell them that (.) haemorrhage
41. → right
42. Nurse 1: uh
43. Nurse 2: it is as usual (.) that patients
44. have got haemorrhage (.) there is
45. bleeding at night
46. Nurse 1: it is haemorrhage (.) that (.) can
47. not be staying [still
48. Nurse 2: [can not stay calm
49. (.) a doctor said that she can not
50. stay still (.) there must be
51. curettage
52. Nurse 1: it is the same one as miscarriage
53. RIGHT
54. Husband: if we pack stuff for hospital (.)
55. we (.) tell them that (.) there is
56. haemorrhage
57. Nurse 2: uh
58. Nurse 1: when (.) at dawn (.) tell them
59. [straightway
60. Nurse 2: [last
61. [night (.) there was haemorrhage]
62. Nurse 1: → [>well (.) there was bleeding (.)
63. → have] to see the doctor first<
64. °others° will not go (.) they
65. will follow in late morning or
66. even in the afternoon (.) have
67. you stayed with mum?
68. Patient: living in different homes
69. Husband: my cousins will suspect (.) why we
70. come here
71. Nurse 1: tell them about haemorrhage (.)
72. there was bleeding last night (.)
73. she said (.) feeling hurt (I)
74. will take (her) to the hospital
75. first right (0.2) LIKE THAT

In line 3, the patient's husband posed a question as to whether he was able to claim cancer as a cause for his wife being admitted to hospital. One of the nurses strongly recommended that the patient and her husband should claim that a haemorrhage which had resulted in miscarriage was the preferred response if they were asked anything related to the hospital admission. Such an account seems to be more logical and reasonable. In the next sequence, the nurse strongly agreed with the recommendations given by the first nurse, as shown in lines 9-10. In

addition, the second nurse elaborated that a pregnancy cannot be continued when it ends in miscarriage. A nurse explains to the patient's husband that haemorrhage has the same meaning as a miscarriage. In lines 18-20 and 22-29, one nurse tries to explain to the patient's husband that a miscarriage can occur naturally. This means that an account of miscarriage may be more appropriate than an account of cancer. After the patient's husband fully understood the recommendations of the two nurses, he quite agreed with it, as shown in lines 40-41. He stated that when he packed items for the hospital, he would tell others that miscarriage was the main reason for his wife being admitted to hospital.

The patient's husband also agreed that if he claimed that a haemorrhage occurred, others would not have suspicions regarding infection and abortion. In this context, haemorrhage is preferable to abortion as it seems more socially acceptable socially. In addition, one nurse recommended that the patient's husband use a tactic of drama to hide the abortion. The nurse advised the patient's husband to be forthcoming with the news of 'bleeding' and tell people before any questions are raised. The patient's husband was recommended to imitate the nurse's quicker sentence, as shown in lines 62-63 '>well (.) there was bleeding (.) have] to see the doctor first <...'. It was uttered at a quicker pace in contrast to the surrounding talk. This tactic can be seen as a means to divert the audience's interest.

The following excerpt shows how the patient's husband worries about confidentiality.

6.30 [01 – 13:03] [AUDIO]

- | | | |
|----|----------|----------------------------------|
| 1. | Husband: | if I told them about haemorrhage |
| 2. | | (.) they would not detect right |
| 3. | Nurse 1: | uh (.) uh |

At the end of the conversation, one nurse took the female patient to see a doctor. She was informed that her pregnancy was quite advanced, and thus she needed to have the abortion at the provincial hospital because it was well-equipped. During the consultation, the doctor explains that the patient and her husband should consider contraception in the future. This is because the patient was infected with HIV, and also because she should not have another abortion again because it is

sinful. However, the doctor let them make the decision on their own.

The same nurse talked to another couple who were both HIV positive. They came to the hospital with a young boy to see the nurse about health care. However, several other themes emerged during the counselling. Confidentiality and stigma were one of the themes discussed. On the subject of confidentiality, the nurse recommends that the patients answer their neighbours' questions tactically.

6.31 [07 – 05:54] [VIDEO]

[The patients were a couple. Neither patient was on the ARV programme. They had a son who was waiting to have his blood tested.]

- | | | |
|-----|-----------------|--|
| 1. | Female patient: | they asked as well right (.) |
| 2. | | sometimes the doctor made an |
| 3. | | appointment for something I told |
| 4. | | them like this (.) the disease (.) |
| 5. | | got anaemic (.) I told them like |
| 6. | | that |
| 7. | Nurse: | uh uh ((nodding)) ((nodding)) |
| 8. | Female patient: | (I) told them that the doctor made |
| 9. | | an appointment ((shaking head)) |
| 10. | | did not have any injection at all |
| 11. | Nurse: | uh ((nodding)) |
| 12. | Female patient: | did not have any injection (.) (I) |
| 13. | | had gone for checking my health |
| 14. | | sometimes (.) they asked me (.) |
| 15. | | were you going to collect milk |
| 16. | | powder? I answered 'right' |
| 17. | Nurse: | → uh (.) uh (.) uh if we cannot |
| 18. | | → answer ((stretching hand)) them |
| 19. | | → properly (.) keeping hesitating |
| 20. | | → ((pointing)) mind the table (.) |
| 21. | | → they will suspect ⁷⁵ |
| 22. | Male patient: | ((touching the boy)) |
| 23. | Female patient: | right (.) (I) did not [hesitate |
| 24. | Nurse: | [mind the |
| 25. | | head of your son ((smiling)) |
| 26. | | ((moving away the table)) |
| 27. | Female patient: | naughty right |
| 28. | Male patient: | ((smiling)) |
| 29. | Nurse: | uh: move there (.) you will not |
| 30. | | get hurt ⁷⁶ |
| 31. | Female patient: | in the future (.) they will not |
| 32. | | suspect us (.) <u>any::thing</u> |
| 33. | Nurse: | → ah ah if we <u>hesitate</u> (.) then |
| 34. | | → ((moving hand)) they will keep |
| 35. | | → nosily asking |

⁷⁵ In between line 21 and line 22, the patients' son who was a young child boy, was moving his head to the corner of the table.

⁷⁶ The nurse was murmuring to the patients' son.

In the excerpt, the nurse strongly recommends that they answer any questions as quickly as possible in lines 17-21 and 33-35. They have to try not to let any gaps or pauses emerge while answering questions. This is because other people might be suspicious, if both patients can not produce quick answers. They should not hesitate to answer questions as if they have nothing to hide. This tactic can be seen as a mechanism for avoiding answers that might lead to revelation of infection by camouflaging the secrecy with apparent transparency. With this subject, the nurse can educate her patients about natural and expected pauses and gaps in conversation.

6.6.4 Sexual transmission and health education

Sexual transmission and health education is an issue of concern amongst counsellors. Nurses are afraid of further spread of infection or the risk put on people who have sexual contact with patients. Consequently, in talking about confidentiality, nurses include whether sexual partners have been told about the patient's infection. Sexual transmission and confidentiality is shown in the chapter on sexuality.

In talking about confidentiality, we have so far concentrated on patients revealing their infection. However, there is also an association between confidentiality and medical ethics. As the counsellor performs a health education role, she must maintain confidentiality in accordance with medical ethics. The scene illustrates the potential conflict between the counsellor's concept of confidentiality and that of the patient. One female patient came to the hospital and talked to the counsellor she used to visit in the past. At that time, this counsellor had seemed to let her patient become a victim of infection. In other words, in the past, this patient had come for a blood test before marriage and she was not informed that her husband had been infected with HIV, either by her husband or her counsellor. The following excerpt illustrates the tactics used by the counsellor when explaining professional ethics, specifically the combination of hypothetical information and the use of the third person.

6.32 [08 – 01:43] [VIDEO]

[The counsellor was a psychologist. The patient was a widow. Her husband committed suicide by shooting himself dead. The patient was on the ARV

programme.]

1. Patient: ah:: ((pointing)) test (.) after
2. testing blood right (.) before
3. testing ((stretching body)) I had
4. told already °test before
5. marriage°
6. Nurse: ah (.) ah (.) ah (.) ah
7. Patient: if I only knew ((pointing)) if
8. you had told me that err:: boy
9. friend had got ((moving hand))
10. that ((grinning)) ((waving hand))
11. Nurse: uh
12. Patient: then I would not have been
13. {like this hhh
14. Nurse: → [uh ((nodding)) at that time he
15. → said that he would have told you
16. → later on his own
17. Patient: uh
18. Nurse: that meant that (he) wanted to
19. talk personally ((moving hands))
20. no matter how (he) would have told
21. Patient: uh

The data show that this counsellor was strongly aware of medical ethics and that she was not able to reveal anybody's infection unless he or she agreed to it. Indeed, the counsellor expected her male patient to inform his wife of his own infection, as shown in lines 14-16. However, the counsellor's expectation was not met. As a result, it seems that she let her patient be infected with HIV. During the consultation, this female patient blamed her counsellor for her infection and asked why the counsellor did not inform her about her husband's infection before they agreed to be married.

6.33 [08 – 02:16] [VIDEO]

1. Patient: → asked him several times
2. Nurse: uh ((nodding))
3. Patient: laboratory in the provincial area
4. also said the same thing (.) well
5. (.) go to talk personally
6. Nurse: uh
7. Patient: that ((moving hand)) because I
8. did not understand the meaning
9. they told ↑right?
10. Nurse: that should ((nodding)) imply
11. Patient: but they did not tell like
12. ((shaking head)) that
13. Nurse: uh
14. Patient: they should whisper or something
15. (.) to imply right

16. Nurse: → like this (.) suppose if I told
 17. → right (.) ah (0.2) that he had
 18. → claimed that his own right (.) he
 19. → would have told on his own (.)
 20. → that would be wrong (.) that
 21. → was not good

The excerpt shows that although the patient tried to find out the result of her husband's blood test, she was not told it by anyone, including her counsellor. Although she asked her husband several times, he also resisted telling her before their marriage, as shown in line 1. At this point, the counsellor provides her reason for her own concealment, and that is she has to follow medical ethics. In the preceding excerpt, the counsellor claimed that professional ethics were sacred and she must maintain the confidentiality of all patients. It would be wrong if she revealed any patient's secret, shown in lines 16-21. Claiming medical rules and regulation as her a defence can be seen as the best way for this counsellor to make her account transparent. In addition, the counsellor also employs a combination of hypothetical information and fictitious accounts of a third person. This tactic is used to protect herself from getting involved with personal difficulties in the medical setting.

6.6.5 Emotional and domestic life

Emotional consequences can include shame, fear and fear for the future of their children. Patients feel ashamed if they let someone know their infection status. They have fear for their lives and some patients have fear for the future of their children. Notably, they have fear for who will look after their children in the future or that their children will be discriminated against. Patients are afraid of being rejected and deserted by family, husbands and children. These worries are thus covered in counselling sessions. Nurses encourage patients to speak out their emotions and concern. The following example is the next sequence of example # 6.18; it shows the discrimination in the family, which brings the patient emotional strain. The patient feels ashamed as she is the cause of the defamation.

6.34 [31 – 14:55] [VIDEO]

[This patient married a man who already had a wife. Her husband subsequently left her. She was on the ARV programme.]

1. Patient: ((nodding)) she said that (.) she
 2. was ashamed ((moving hand))
 3. Nurse: ((tossing head))
 4. Patient: to other people (.) others blamed
 5. ((touching hair)) her
 6. Nurse: ((tossing head))
 7. Patient: many [things.
 8. Nurse: [you did not search for
 9. Patient: um ((nodding))
 10. Nurse: this sort of thing ((twitching
 11. finger))
 12. (0.2)
 13. Patient: → blamed that °pregnancy without a
 14. → husband° ((touching the desk))
 15. → (.) many things (.) mum blamed
 16. → me ((looking down)) she felt
 17. → ashamed (.) felt ashamed

The data show that the patient was discriminated against in the family. At the beginning, the nurse made an attempt to allude to whether the patient was discriminated against using a cultural question of eating together, as shown earlier in example # 6.18. The patient still ate together with her family, but she was blamed by her mother when her infection was revealed. She went to a beauty salon for a haircut and was discriminated against by other customers. The hairdresser told her mother to inform the patient that after she had left the salon, other customers did not come for services because they were afraid of being infected. This made the patient's mother disappointed, and her mother told her that she blamed her and felt ashamed that the patient was infected, pregnant and left by her husband, as shown in lines 13-17. Her infection seems to bring defamation in her family.

6.7 Conclusion

For patients, the issue of who knows and who does not know of their infection is still a contemporary problematic issue. Patients have their own reasons for secretiveness. Language and non-verbal communication are important means by which to maintain their confidentiality. We have seen the nurses use general questions, and move to specific questions, sometimes including a key word, in order to initiate the topic in counselling sessions.

In addition, a normal requesting question, such as whether the nurses can visit the patients at home, can allude to confidentiality to some extent. In the context of HIV counselling, the nurses have sometimes used repairing questions to clarify what it is they desire or what needs to be confirmed. Furthermore, cultural dimensions such as eating together and social participation can be used in relation to confidentiality. This chapter also illustrates tactics used by the patients to account for their resistance in telling others. Additionally, the use of strong formulations, turning hypothetical into actual situations, balancing and paradox all demonstrate the concern with which counsellors and patients regard the topic of confidentiality. In addition, the advice nurses give their patients has been illustrated in this chapter.

The next chapter shows another theme in counselling, which is sexuality. I show who initiates the topic, and how the topic is managed. The chapter illustrates how the delicacy, sensitivity and awkwardness in talking about sexual conduct is handled. In addition, the chapter also shows the pathway of talking about sexual conduct, sexual practice and sexual behaviour.

Chapter Seven

Sexuality

7.1 Introduction

The link between sex and death are generally associated with AIDS because HIV can be spread sexually (McManus, 1989, p.224). Lyttleton (2000) points out the association between AIDS, sex and its consequences by stating:

'Regardless of the social setting, AIDS has demanded that structure be provided for the profound emotions it creates. Because AIDS deals in the highly charged arenas of sex, illness and death, its symbolic imagery and implications tap deep into psychic realms' (Lyttleton, 2000, p.7).

Perhaps for that reason AIDS and sexuality are often both prominent in news coverage on AIDS. These topics are also raised in counselling sessions because they concern patients very directly. Through counselling theory, nurses as counsellors have been trained to address these. However, explicit discussion about sexuality and death in connection to AIDS may still be regarded as sensitive and taboo to some extent. Rohleder and Swartz (2005, p.403) state that '[c]ounsellors and clients are involved in a confidential and intimate relationship where emotionally loaded topics, such as sex, death and dying, are discussed'.

The way in which this chapter focuses on sexual conduct, sexual practice and sexual behaviour in counselling is by showing observations and findings. Then I illustrate each case with excerpts to underpin what this chapter found. In main findings, I focus on three aspects of sexual conduct covered in the counselling sessions. I show who initiates the topic and the way in which professionals and lay persons address this sensitive topic, including the way these participants approach the sensitivity of this topic. In addition, I describe the different types of question applied by nurses and the pathway of sexual talk. In each feature the pathway leading to sexual discussion is shown alongside the tactics used.

7.2 Three aspects of sexual talk

The data show that, in general, the majority of widowed female patients were not expected to discuss their sexual conduct. However, some of these patients have remarried, and some had new sexual partners and so the topic of sexual intercourse may become salient. Male patients in particular were targeted for discussions about sexuality as some go for commercial sex. In counselling sessions, the nurse expected a single male patient go to buy sex if he is single or his wife died of AIDS. Some heterosexuals and or homosexuals had sexual affairs with new partners. Three aspects regarding sexuality have been drawn upon during the sessions. They can be separated into three reasons for nurses to bring the topic of sexuality into discussion. These are managing public health information, instructing and advising on sexual practice, and sex and well-being.

7.2.1 Managing public health information

One of the important tasks in HIV counselling is to talk about public health. There are three topics mentioned in the managing of public health information in counselling sessions. They are safe sex, the use of condoms and the spread of infection.

The importance of talk about sexuality in HIV counselling is to promote safe sex behaviour in order to reduce high-risk behaviour amongst patients. The term 'safe sex' refers to sex without risk of infection or spread of infection. However, a number of patients refer to masturbation as safe sex, revealing that they had not had any sexual activity with their husbands or partners, and instead, they had used masturbation.

The following excerpt shows the use of masturbation as a way of having safe sex. The female patient remarried after her first husband had died from AIDS. Her new husband was also an HIV patient. She referred to masturbation by her new husband when she was asked questions regarding the sexual relationship between her and her new husband. In theory, masturbation is regarded as one of the good ways of having safe sexual activities. The nurse is trained to implement it in giving the patient advice.

7.1 [33 – 22:56] [VIDEO]

[The female patient is living with a new husband. She was on the ARV programme.]

1. Nurse: did not ((tossing head)) have
2. relations
3. Patient: → ((nodding)) if he comes (.) mostly
4. → he will do ((tossing head))
5. → masturbation
6. Nurse: uh ((---tossing head 5 times---))
7. (0.2) have prevented yourselves
8. Patient: ((tossing head))
9. Nurse: but ((stretching hands)) come to
10. stay together (.) come to be
11. friends (.) each other

At 22:56 minutes, the patient told the nurse that her new husband mostly did his own masturbation as shown in lines 3-5. At the end of the sequences, the patient also told the nurse that both just stayed together.

Apart from masturbation, most patients understand well that safe sex is important, and that it is linked with condom use. Condom use is always underlined in health consultations. A number of patients refer to the use of condoms as an effective way of protecting themselves. During the first day of the community programme at the XV International AIDS Conference in Bangkok, condoms were underlined as a key component of prevention strategies. Condoms have played a decisive role in preventing HIV in many societies (The Community Program Rapporteurs Team, 2004). This indicates that safe sex is currently the key issue that is emphasised amongst both uninfected people and people living with AIDS.

Nurses always ask patients whether they use a condom when having sexual intercourse. Female patients were asked to confirm whether their sexual partner used a condom, the purpose being to assess whether people understand condom use correctly. The following example shows the discussion on condom use.

7.2 [01 – 08:12] [AUDIO]

[This session was recorded on audio cassette. Two nurses talked to the couple. The husband was still HIV negative, but the wife was HIV positive. They came to discuss a possible abortion with counsellors.]

1. Nurse: → normally (.) beg your pardon
2. if sleep together (.) did wear

3. condoms? or never used
4. Female Patient: did not use [because
5. Husband: [did not use (.)
6. [because
7. Female patient: [confident
8. Nurse: uh (.) uh (.) uh

In the above excerpt, the topic was opened up by the nurse, and she wished to know whether the patient and her husband used condoms. The nurse uses an apologetic form by stating 'beg pardon', in line 1. Significantly, apologetic forms were not found in data used in this context. In this case, it was not used to initiate the topic of sexuality, but rather to continue interaction.⁷⁷

In addition, the spread of infection is another aspect, highlighted with regard to public health information. The nurse attempts to find out whether her patient understands how this disease is spread because their training and experience leads them to expect that patients only partially understand, or fully misunderstand, the way in which this disease is spread. For example, the patient in case no.10 told the nurses that the disease could be transmitted by drinking alcohol.⁷⁸ The nurse finds an appropriate way to make clear the way in which the infection is spread. Thus the nurse wishes to correct her patient in order to restrain her patient from spreading infection to other people.

7.2.2 Instructing and advising on sexual practices

The nurse instructs and advises patients on the subject of the spread of infection, for the sake of social responsibility. The patient must not spread infection to other people who have contact with them. For example, the patient was reminded to use a condom. The data show that the nurse is working for the benefit of people who are not her patient, which is not what one expects from regular counselling. The nurse and the patient discuss individually the sense of well-being and social responsibility. The patient must use a condom; the patient will not be transmitted other viruses during sexual intercourse. This should make the

⁷⁷ The nurse helps them clarify who brought the infection into the relationship. Both patients admitted that they did not use condoms. The female patient was infected and her husband denied that he ever had sexual intercourse with other girls. This led him to say that he did not use condoms because he felt confident with his sexual behaviour. The patient revealed that she had been married before.

⁷⁸ See excerpt # 7.12 as shown in lines 7-8.

patient healthy and live longer. In addition, using a condom is a way to prevent other people being transmitted the virus from the patient. Thus advice which is given to patients, is not simply for the benefit of the individuals, but they are meaningful to other people who may come into contact with, or get involved with patients. Having been advised, the patient is expected to refrain from or stop spreading infection. Of course, the nurse cannot force her patient not to spread the disease. Thus she must apply tactics to convince the patient of the need to avoid any spread of infection. The nurse attempts to make her patient take in every message as much as possible in order that the patient will prevent himself or herself from further spreading of the infection. In other words, the view that the spread of infection is unacceptable is impressed upon most patients by being underlined in sequences of talk.

The following case is no. 39. It clearly shows that the counsellor instructs and advises her patient on the subject of the spread of infection.

7.3 [39 – 18:55] [VIDEO]

[The counsellor was a midwife. The female patient was a widow, and a single mother. She was not on the ARV programme.]

- | | | |
|-----|----------|--|
| 1. | Nurse: | on 17 th that you come (.) I will |
| 2. | | check it for your daughter |
| 3. | Patient: | ((nodding)) right |
| 4. | Nurse: | → and (.) I worry about you |
| 5. | | → regarding health ((counting)) |
| 6. | | → please look after yourself well |
| 7. | | (0.1) don't go::: (0.2) think |
| 8. | | that ((moving forwards to |
| 9. | | patient)) ((staring at the |
| 10. | | patient)) ((touching the patient's |
| 11. | | → leg)) (.) I worry the most is the |
| 12. | | → spread of infection (.) do not |
| 13. | | think (.) you (.) have to blame |
| 14. | | all men (.) all the world (.) is |
| 15. | | not like that (.) think of their |
| 16. | | (.) children (.) wives also |
| 17. | Patient: | ((smiling)) uh |

In this excerpt the counsellor made an attempt to allude to whether the patient spreads the infection or not. She does not initially address such a topic directly and had to approach the subject by subtly initiating conversation about the patient's desires for a second marriage. The way in which the counsellor continued the conversation onto the spread of infection was by addressing the

patient's own individual sexual practice. The counsellor told her patient that she worried about the patient's health. The patient was told to look after herself, as shown in lines 4-6. It becomes clear in the same turn, in lines 11-12, that the counsellor is really concerned about the spread of infection, and in that way is encouraging the patient to conduct herself in a socially responsible fashion.

7.2.3 Sex and well-being

Sex plays a paramount part in well-being and the nurse discusses the close relationship between sexual activities and well-being. Most nurses refer to cross infection from another sexual partner, if the patients were to not use a condom. In addition, the nurse shows that, as well as taking ARVs, the patient can look after himself or herself by having safe sex and using a condom and by being sensible even in non-sexual activities.

The following excerpt illustrates the relationship between the patient's belief about sexual activity and good health. The male patient acknowledged that he had sexual relations with girls several times a month, even though he was told during some training that having frequent sex with multiple partners was high-risk behaviour.

7.4 [16 – 29:47] [VIDEO]

[The male patient is the leader of HIV patient's network. He was on the ARV programme.]

- | | | |
|-----|----------|---|
| 1. | Patient: | ((smiling)) as we conclude that |
| 2. | | (.) one has had sex and the immune |
| 3. | | system becomes lower (.) but for a |
| 4. | | woman who has not had a husband |
| 5. | → | and <u>SEX</u> (.) she also dies |
| 6. | → | [early |
| 7. | Nurse: | [deteriorated |
| 8. | | ((nodding)) |
| 9. | Patient: | also <u>deteriorated</u> ((clasping hands |
| 10. | | together))((nodding)) it::: (0.1) |
| 11. | | is not related to (.) if ((putting |
| 12. | | hands together)) ((moving hands)) |
| 13. | | look after and eat healthily (.) |
| 14. | | that better (.) we do not (0.1) |
| 15. | | have::: sexual relations everyday |
| 16. | | (.) we have to know that (.) when |
| 17. | | (we) are exhausted (.) must be |
| 18. | | flexible right ((laughing)) |
| 19. | Nurse: | ((smiling)) |

20. Patient: >oh, I am exhausted ((moving
 21. body)) then still [shag<
 22. Nurse: [uh (.)
 23. can't [be
 24. Patient: [can't be

At 29:47 minutes, the patient claimed that having frequent sexual relations did not make him worse. By contrast, it rendered him happy and when he became happy, he looked healthy. During the health consultation, the patient argued that he did not agree with the view that if one has frequent sexual encounters, one tends to die earlier. He showed his reasoning by referring to a patient who was a widow, and who had not had a new husband or sexual activities. Despite this, she also died early in lines 5-6. Thus patients should be healthy if they look after themselves and eat well, but not because they refrain from frequent sexual activities.

7.3 Topic initiator

The sensitivity of the topic of sexual conduct is evidenced by the fact that in only 2 cases did patients initiate this topic⁷⁹; but in all other cases it was the nurse who initiates. However, nurses introduce the topic in an indirect step-by-step approach, rather than directly or abruptly.

Topic raised by nurses: The topic of sexuality is mostly initiated by the nurse even though the discussion is likely to be of concern to patients themselves. The way in which the nurse addresses the topic is reflected in different types of question, language and gestures used in talking.

Topic raised by patients: In the few cases in which the topic of sexuality is initiated by a patient, they also initiate the topic rather indirectly. A patient who brings the topic of sexuality into discussion has his or her own techniques in

⁷⁹ The patient in case no.04 identified himself as male homosexual, and he initiated the topic. Further discussion is shown in the following section. Another patient who initiates the topic is the female patient in case no.13. She initiates it by asking for condoms from the nurse. However, in this case, there is no further discussion of sexuality. At 22:58 minutes, the patient asks for condoms stating 'have ((moving body)) ((looking at the table) you got con ↑doms'. The patient asking for condoms may be relevant to a gender issue to some extent. It may indicate that prevention and contraception seem to be the responsibility of female patients, even though those condoms are used by men.

rendering it sensitive. He or she uses spoken words and gestures to mark the topic of sexuality as sensitive and important. The way in which the nurse and the patient initiate the topic of sexuality is addressed in the following sections, and the type of question and the pathway of sexual talk is demonstrated.

7.4 Type of question

In most cases, four types of question are used to introduce the topic of sexual conduct into the discussion. The issue is typically raised after the course of infection and the background of the patient have been discussed. In addition, the use of one single type of question is not practical for talk in the context of sexual conduct. Thus, in most cases, multiple questions are required to talk about it. At this point, the four common types of question should be demonstrated.

7.4.1 General question

In some cases, the counsellor desires to know about the preventative measures taken by her patient and their partner. The nurse produces a type of question, known as a general question, to allude to sexual behaviour. The characteristic of this question is such that it may allude to something else more than it seems to if interpreted literally. However, the ultimate purpose is to elicit information about sexual behaviour and the prevention of infection. In this area, 'prevention' means the frequency of condom use. The nurse uses this question by asking 'how do you look after yourself' or 'how do both of you look after yourselves'. The following case shows the use of general question to allude to, and hence indirectly address the topic of sexual conduct.

7.5 [42 – 15:07] [VIDEO]

[The patients were a couple. Both were on the ARV programme. The male patient passed away after the researcher left the research site. The female patient was living with her daughter.]

- | | | |
|----|---------------|----------------------------|
| 1. | Nurse: | uh (0.2) and until now (.) |
| 2. | | nowadays |
| 3. | Male patient: | ((looking down)) |

- | | | | |
|-----|-----------------|---|--------------------------------|
| 4. | Nurse: | → | °how do ((moving legs)) (you) |
| 5. | | → | look after (yourselves)° in |
| 6. | | | family when (both of you) have |
| 7. | | | known (0.2) >do you still |
| 8. | | → | mutually have like normal< |
| 9. | Female patient: | → | [no ((slightly shaking head)) |
| 10. | Male patient: | → | [((shaking head)) no ((shaking |
| 11. | | | head)) no ((looking down)) |

The above example shows the nurse using a general question in lines 4-5 by asking how both patients looked after themselves. In the same turn the nurse uses the repairing technique of a specific question to clarify what she really means. The nurse wishes to know whether they practise safe sex and in line 8, the nurse uses a euphemistic form 'mutually have'. These utterances have been interpreted in precisely the same way by both patients, as shown in lines 9-10 where the patients produced overlapping answers that they had not had sexual relations. However, the nurse may not be provided with adequate information on how the patients look after themselves and take preventative measures during their sexual activities by a general question. As a result, the nurse moves to another question, which is referred to as a specific question.

7.4.2 Specific question

As stated earlier, a specific question is not used independently, but is employed following a general question. When the nurse has had insufficient information from her patient in response to a general question, and is struggling to probe about sexuality due to a short answer, the nurse has to move to another type of question called a specific question. This type of question is extremely direct and helps the counsellor overcome a short answer. In order to use this kind of question efficiently, the nurse sometimes has to modify it in each turn until she obtains what she is seeking. The following case shows the use of a specific question by a nurse. The nurse discussed the family background and sexual affairs of the patient. However, the data show that the nurse did not believe what the patient told her, thus she had to modify her questioning in the following turns.

7.6 [03 – 13:03] [AUDIO]

[The counsellor was a midwife. The male patient was single. He was not on the

ARV programme. He was too embarrassed to allow video recording. However, he voluntarily gave permission for audio recording.]

1. Nurse: → now have you gone for girls
2. Patient: have not gone (.) right (.)
3. staying at home
4. Nurse: let me ask (.) that now do you
5. → still have sexual need
6. Patient: still do
7. Nurse: do not be shy to auntie⁸⁰
8. Patient: right
9. Nurse: I have already had a husband (.)
10. children (they) are already
11. teenagers
12. Patient: right
13. Nurse and now how do you solve the
14. problem (.) as in your life (.)
15. have always gone over time slept
16. with girls
17. Patient: right
18. Nurse: then now (.) how to solve
19. the problem
20. Patient: → gone to brothel
21. Nurse: now (.) have gone to brothel
22. Patient: right

The above excerpt shows the counsellor initiated the topic of sexuality by using a direct specific question as shown in line 1. The counsellor asked her patient whether he had gone to a brothel. In this case, asking a direct specific question is one way to make it clear that the discussion is about sex. Although the patient seems to understand what the counsellor had been asking, he was reluctant to reveal his sexual behaviour at the beginning. Thus, he replied to the question in the prior turn by stating that he had not gone to a brothel. The data show that the counsellor was sceptical about the patient's assurances. The counsellor then modifies her questions in the next turn, as shown in line 5, asking whether the patient had any sexual needs. This time, the counsellor was successful because the patient acknowledged that he still needed sex. At this point, the counsellor picked up on this admission, and probed further until the patient acknowledged that he had gone to a brothel, in the next turns shown in line 20. This case clearly shows the use of different specific questions enabling the counsellor to focus increasingly and directly on the patient's sexual behaviour.

However, in some cases, although the counsellor uses a specific question to obtain information, she may still not be successful due to a patient's resistance

⁸⁰ By referring to herself as 'auntie' she downplays her professional status.

through a short answer. It is evident that it may not always be practical to use a specific question. The way in which the counsellor solves this problem is by applying affirmative statements as a mode of information delivery. The following case illustrates the use of direct specific questions with affirmative statements.

7.7 [03 – 12:37] [VIDEO]

[The patient was infected by her ex-husband. She is living with a new husband who was still found to be HIV negative. She was not on the ARV programme.]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | → | stay together (.) have any sexual |
| 2. | | → | intercourse? |
| 3. | Patient: | | now (.) no ((shaking head)) in the |
| 4. | | | evening had dinner (.) watched |
| 5. | | | television (.) TV |
| 6. | Nurse: | | ((nodding)) ((nodding)) |
| 7. | Patient: | | went to bed ((tossing head)) most |
| 8. | | | of the time (.) I slept first |
| 9. | | | ((laughing)) ((looking down)) |
| 10. | Nurse: | → | ((nodding)) ((smiling)) but |
| 11. | | → | husband did not say ((shaking |
| 12. | | → | head)) did not::: complain |
| 13. | | → | anything of it |
| 14. | Patient: | | I (.) mostly I ((pointing chest)) |
| 15. | | | normally said ((laughing)) |
| 16. | Nurse: | | right ((smiling)) |
| 17. | Patient: | → | he would blame (.) do not say |
| 18. | | → | ((tossing head)) do not think |
| 19. | | → | ((tossing head)) |
| 20. | Nurse: | | uh ((nodding)) uh ((nodding)) |
| 21. | Patient: | → | keep thinking (.) getting worse |
| 22. | | → | (.) do as usual ((tossing head)) |
| 23. | | → | ((moving hands)) |

The excerpt illustrates how the nurse uses a specific question to probe how the patient and her husband conduct their sexual relationship. In lines 1-2, the nurse asked her patient whether she and her husband had sexual intercourse. In the next turn, the patient states that she and her husband did not. However, the nurse probed further by using affirmative utterances by enquiring whether the patient's husband said anything or complained about it in lines 10-13. The nurse expects to obtain the actual answer on their sexual life. At the end of the sequence, the patient told the nurse that her husband did not want her to worry about anything because it might make the patient worse in lines 17-19, and 21-23.

7.4.3 Allusive question

As we have seen, the nurse sometimes alludes to whether or not the patient practises safe sex. Thus, the way in which the nurse alludes to it is by employing an allusive question. The characteristic of this question is that it can be used independently. The nurse may pick up on the external appearance of a patient to probe further regarding sexual intercourse in relation to the spread of infection. In such cases the nurse will use an allusive question by asking whether the patient has been approached by anybody. In other words, the nurse asks her patient whether anybody fancies them-plainly probing whether the patient has or is tempted to have sexual intimate relations with others. The nurse alludes to the spreading of infection by the patient as in these examples.

7.8 [38 – 04:13] [VIDEO]

[The counsellor was a midwife. The female patient was a widow. She was not on the ARV programme.]

- | | | | |
|----|----------|---|-----------------------------------|
| 1. | Nurse: | → | and (.) are there ((separating |
| 2. | | → | hand)) ((clasping hands |
| 3. | | → | together)) that any (men) would |
| 4. | | → | like to become something else (.) |
| 5. | | → | to be boy friend (.) or else |
| 6. | Patient: | | to be a boy friend (0.1) |
| 7. | | | ((nodding)) there is |

7.9 [39 – 13:20] [VIDEO]

[The counsellor was a midwife. The female patient was a widow, and a single mother. She was not on the ARV programme.]

- | | | | |
|----|----------|---|------------------------------------|
| 1. | Nurse: | → | then (.) nowadays (.) ask (you) to |
| 2. | | → | be honest working at construction |
| 3. | | → | site (.) have got anybody (.) come |
| 4. | | → | asking (.) ↑courting |
| 5. | Patient: | | have ((smiling)) have also |
| 6. | | | ((touching neck)) |

These two examples illustrate the use of allusive questions for obtaining more information on sexuality. In example # 7.8, the counsellor asked her patient in lines 1-5 whether any men had approached her. In the next turn, the patient stated that she had had one boyfriend while she was working at a restaurant. In example # 7.9, the counsellor made an attempt to allude to the sexual affairs of the patient

by using an allusive question in asking whether the patient had been approached or courted by any men, as shown in lines 1-4.

7.4.4 Hypothetical question

The hypothetical question is also used by the nurse to obtain information on the sexual affairs of patients. In some cases, the counsellor uses this kind of question to know how the patient behaves in sexual activities. The nurse uses the word ‘if’ as a hypothetical form in her turn to say in case they have had sexual intercourse. The following example demonstrates the use of a hypothetical question by the nurse.

7.10 [33 – 22:42] [VIDEO]
[The female patient is living with a new husband. She was on the ARV programme.]

- | | | | |
|-----|----------|---|-----------------------------------|
| 1. | Nurse : | → | but (.) ask a bit |
| 2. | Patient: | | ((clearing throat)) ((clearing |
| 3. | | | throat)) |
| 4. | Nurse: | | more (0.1) this |
| 5. | Patient: | | ((clearing throat)) |
| 6. | Nurse: | | quite ((tossing head)) profoundly |
| 7. | Patient: | | ((tossing head)) |
| 8. | Nurse: | → | if (.) sleep together? |
| 9. | Patient: | | mostly just slept (.) did not |
| 10. | | | have affairs (.) talked to each |
| 11. | | | other |

The above excerpt illustrates the nurse needs to know whether the patient and her new husband have safe sex. Thus she initiated asking her patient how she would behave if she slept with her husband, stating ‘but (.) ask a bit’, shown in line 1. The utterance ‘if’ in line 8 is referred to as a hypothetical form of question.

7.5 The pathway of talk on sexuality

I am going to show an exemplar from a counselling session. In close analysis of it, a clear pathway of talking on sexuality is apparent. The talk is between a nurse and a drug user. The nurse initiates the topic and most of the talk is concerned

with the spread of infection. The talk appears similar to a classroom interaction. The patient takes on a student role, and the nurse acts as a teacher. Thus their talk is asymmetric. The patient is given advice in lengthy sequences, and the nurse makes an attempt to convince her patient to refrain from marrying again.

7.11 [10 – 31:59] [VIDEO]

[The patient was a drug user. He is divorced from his wife. His daughter lives with his wife. He is living with his parents. He was on the ARV programme.]

1. Nurse: and ((stretching hand)) think that
2. (.) the past has gone ((moving
3. hand)) used to have wife and
4. → think that (.) would like to work
5. → ((counting)) like that if get
6. → money (.) will marry ↑again
7. Patient: ↓mar::ry ((nodding))
8. Nurse: will ↑marry ((stretching body))
9. again
10. Patient: ↓right
11. Nurse: though (you) have been like this
12. Patient: right (.) ((nodding)) (0.2)
13. would like to have a family
14. Nurse: → would like to ((stretching hand))
15. → have a family ((pointing)) family
16. → ((pointing)) of you what you mean
17. Patient: ((scratching ear))
18. Nurse: → mean (you) whether can have
19. → children? (0.1) you want to have a
20. → child
21. (0.1)
22. Patient: → would like to-
23. Nurse: → ((laughing)) ((stretching body))
24. → ((moving backwards))
25. → ((---tapping the patient's arm 3
26. → times---))
27. Patient: → right (.) but now (I) do not have
28. → (.) that girl friend
29. Nurse: → (I) ((retracting hand)) understand
30. ((nodding) now (.) you do not have
31. (.) but ((showing one finger)) I
32. will ask you in the future (.) you
33. would like to have a family again
34. Patient: right ((nodding))
35. Nurse: → though you have been like this
36. → ((moving hand))
37. Patient: right

At 31:59 minutes, the nurse opens the conversation on sexuality and the spread of infection by addressing a general issue in lines 4-6. The nurse initially talks about the patient's background. The patient used to be married, but is divorced from his ex-wife. The nurse asked her patient about his marriage. The patient

acknowledged that he wished to marry a second time as shown in line 7, by stating '↓mar::ry ((nodding))'. He revealed that if he was employed, he would find a woman for marriage. In addition, he told the nurse that he wished to have a child. This indicates that he would have sexual intercourse without using a condom, and the disease could be spread to his new wife if she was still negative, and more importantly, to the new born child. In this area, his wishes may jeopardise his new wife and newborn child. This can be regarded as sensitive because his response is meant in relation to the spread of infection and lack of social responsibility. The counselling nurse is aware, through her training, of the relationship between social responsibility and the spread of infection. Thus, one task of counselling is to stop any patients from spreading infection by getting them to have safe sex and use condoms. The nurse checks what the patient really means, as shown in lines 14-16 and 18-20.

It is not surprising that the nurse immediately displays her concern when she is convinced about what the patient is proposing to do in the future. The nurse expresses reservation on what she is told. In line 22, the patient still proposes that he would like to get married again and the data seem to show that the patient does not recognise the fact that his action is problematic. It is clear that his turn, in line 22, is curtailed by the nurse, who cuts his turn off by illustrating the nurse's disagreement with the patient's confession.

Here, I should illustrate how the nurse and patient show the sensitivity in the topic. The nurse used gesture and body movements when she focuses on the spread of infection. In lines 23-26, she laughs, stretches her body, moves backwards and taps the patient's arm. The way in which she laughs should not be treated as serious, or ridiculous by the patient. The nurse laughs at her patient in a sympathetic manner followed by the disagreement. This action is to mitigate the impact of the laughter. In addition, the nurse taps the patient's arm three times. This action is projected to correlate with the recipient's turn and is intended to persuade the patient not to marry again. While the nurse is tapping the patient's arm, the patient produces utterances in stating that he has not had a girlfriend, as shown in lines 27-28. The data show that the patient recognises the sensitivity of his statement in some sense because he states 'right' at the beginning of the turn in line 27. At this point, the nurse waits until the patient finishes his turn, then the nurse retracts her hand, but she stops it near the patient's arm as shown in line 29.

In other words, she does not completely withdraw her hand. The nurse stays her hand in this position in order to keep it still. This action clearly indicates that what she is doing has not yet finished. She aims to do something in her next turn. This action is correlated with the next turn design of the nurse. Connecting on the patient's assertion that he would like to get married, even though he has been infected with HIV, when she states 'though you have been like this ((moving hand))', as shown in lines 35-36. In this sense, she uses such gestures to show that she is scared, fully alert and surprised whether the patient knows how this infection is spread.

Her gestures are used to delay the patient's thoughts. In addition, the patient's reply is projected to be discussed further as to whether or not the patient knows the relationship between the spread of infection and his wish. The nurse uses this technique when she wishes to stress whether the patient is aware of the implications of what he is considering. In the next sequence, the nurse asks questions designed to assess the patient's knowledge regarding the spread of infection.

7.12 [10 – 32:37] [VIDEO]

- | | | | |
|-----|----------|---|---|
| 1. | Nurse: | → | do you know how this disease is |
| 2. | | → | transmitted? |
| 3. | Patient: | → | many ways |
| 4. | Nurse: | → | just say |
| 5. | Patient: | | infected |
| 6. | Nurse: | → | ((showing an index finger)) ⁸¹ |
| 7. | Patient: | → | because we take drugs (.) drink |
| 8. | | → | alcohol (.) many things (0.1) and |
| 9. | | | go for the girls ((showing a |
| 10. | | | middle finger)) |
| 11. | Nurse: | → | this AIDS ((nodding)) is |
| 12. | | → | transmitted by drink (.) taking |
| 13. | | | ↑drugs? |
| 14. | Patient: | | right ((nodding)) |
| 15. | Nurse: | | uh (.) ((moving backwards)) |
| 16. | | | ((putting right arm under left |
| 17. | | | arm)) |
| 18. | Patient: | | and go for the girl (.) prostitute |
| 19. | Nurse: | | uh (.) second already and another |
| 20. | | | is |
| 21. | Patient: | | ((scratching nose)) |
| 22. | | | (0.6) that (.) love (0.2) the same |
| 23. | | | (.) men |

⁸¹At this stage, the nurse encourages the patient to tell her in which ways people can be infected with HIV. The nurse shows fingers while waiting for each answer from the patient. The nurse starts showing an index finger, middle finger and ring finger respectively.

24.	Nurse:	→	you ((nodding)) (0.1) understand
25.		→	correctly some parts (.) (I) will
26.		→	(.) tell you again
27.	Patient:		right ((nodding))

At 32:37 minutes, in lines 1-2, the nurse asked whether the patient knows how this disease is spread. The patient's answer in line 3 seems to be a short answer. The patient told the nurse that this disease can be spread several ways. At this point, the nurse forcefully asked her patient to clarify his answer. The 'forceful' term can be seen in line 4 where the nurse uses an imperative form stating 'just say'. The nurse seems to act as a teacher by showing an index finger in order to wait for the answer from the patient. In the next sequence, the nurse continues to test her patient. In lines 24-26, the nurse told the patient that his understanding was partially correct and what the patient misunderstood is shown in lines 11-12 where the nurse repeated the patient's statement that this disease can be transmitted by drinking and taking drugs. Consequently, the nurse clarifies to the patient how the infection can be spread as shown in the next excerpt.

7.13 [10 – 33:23] [VIDEO]

1.	Nurse:		AIDS can be transmitted through 3
2.			ways
3.	Patient:		right
4.	Nurse:		((showing three fingers))
5.		→	((counting)) sexuality (.) that go
6.			for the girl (.) sleep together
7.	Patient:		right
8.	Nurse:		every thing related to sexuality
9.			((nodding)) men sleep with men
10.			((moving fingers))
11.	Patient:		right
12.	Nurse:		women and women (0.1)
13.			women (0.1) and men (.) can
14.	Patient:		right
15.	Nurse:		every kind (.) if have sexual
16.		→	intercourse (.) second (.) blood
17.	Patient:		right
18.	Nurse:		((sweeping hand)) everything about
19.			blood (.) wound (.) accident (.)
20.			knife cutting (.) spots where (.)
21.			there is blood (.) lymph
22.	Patient:		right ((nodding))
23.	Nurse:		of ((stretching hand towards
24.			patient)) (0.1) you (.) that will
25.			transmit into someone else
26.	Patient:		((nodding))
27.	Nurse:		sexuality (.) blood and another
28.			one

29. Patient: right ((nodding))
 30. Nurse: → is mother to child transmission
 31. Patient: right ((nodding))
 32. Nurse: mother to child (.) that is
 33. pregnant woman
 34. Patient: right ((nodding))
 35. Nurse: who is pregnant (.) and has got
 36. virus (.) when child was born
 37. ((pointing down))
 38. Patient: right
 39. Nurse: then will be infected (.) and
 40. then you said that you (0.1)
 41. ((pointing towards patient)) will
 42. have a family again .
 43. Patient: right ((nodding))
 44. Nurse: → if you have got a new wife (.)
 45. → sleep with wife (.) if you would
 46. → like to have a child (.) you do
 47. → not do contraception ((shaking
 48. → head))
 49. Patient: right
 50. Nurse: you have got virus ((touching
 51. fingertip of an index finger))
 52. is it right?
 53. Patient: right ((nodding))
 54. Nurse: → you transmit to wife (.) wife
 55. → transmits to ((pointing down))
 56. → child (0.1) then ((sweeping hand)
 57. → all get AIDS ((smiling))
 58. Patient: right ((nodding))

At 33:23 minutes, the nurse begins to instruct her patient about the transmission of the virus. It is transmitted through sexuality (line 5), blood transfusion in line 16, and mother-to-child transmission (line 30). The nurse then clarifies that if the patient would like to have a child, the patient will not be using contraception in lines 44-48. His infection will definitely be transmitted to his new wife and the infection may be transmitted to his newly born child too (lines 54-57). In line 56, the nurse produces a gesture to make what she is going to say clear. The way in which she moves her hand in a sweeping movement correlates with her utterances 'all get AIDS'. This action means that AIDS will affect everybody; more specifically his new wife and new born child. The next sequences show how the nurse struggles with the patient's reply.

7.14 [10 – 34:22] [VIDEO]

1. Nurse: → this ((waving hand)) ((shaking
 2. → head)) have not known right (.)
 3. → that is why would like to have a
 4. → family

5. Patient: → ((putting elbow on the desk)) but
 6. → ((putting arm down)) HAVE TO get
 7. → a job (.) first
 8. Nurse: that (I) understand ((moving
 9. hand)) suppose that employed earn
 10. a living (.) you do not know do
 11. you (.) that AIDS can be
 12. transmitted to others if you get
 13. married (.) it will be transmitted
 14. to wife (.) wife will get (.) be
 15. infected and then
 16. Patient: → take medicines right (.) take
 17. → ((moving hand)) drugs all the time
 18. Nurse: → taking medicines all the time (.)
 19. → virus is ((waving hand)) not
 20. → disappeared
 21. Patient: right
 22. Nurse: AIDS (.) virus is ((touching
 23. chest)) still in ((nodding))
 24. the body
 25. Patient: → use (.) a condom
 26. Nurse: uh ((nodding)) ((raising hand))
 27. if use condom
 28. Patient: (not infected)
 29. Nurse: ((waving hand)) cannot have
 30. children
 31. Patient: right (.) I will not have
 32. Nurse: right (.) at the moment you said
 33. want a child ((moving hand)) I am
 34. afraid that you will misunderstand
 35. (.) then I explained you
 36. Patient: I have to talk that ((moving
 37. hand)) (we) if we marry first
 38. Nurse: uh (.) [that
 39. Patient: → [that (.) live for two (.)
 40. → three months first if we can get
 41. → married right
 42. Nurse: uh ((nodding))
 43. Patient: → then try to have a child
 44. Nurse → ((stretching neck)) oh::: no!
 45. → ((relaxing)) °you are thinking
 46. → like this° ((smiling)) it is (0.1)
 47. → quite (.) sca::ry ((nodding))
 48. Patient: ((slightly moving body))
 49. Nurse: ((stretching hand to patient))
 50. you have to think when you
 51. ((touching chest)) ((nodding)) had
 52. symptoms ((nodding))
 53. Patient: right ((nodding))
 54. Nurse: in the past ((stretching hand))
 55. Patient: right ((nodding))
 56. Nurse: you had ((pointing)) symptoms
 57. NEARLY die ((nodding))
 58. Patient: ((nodding)) right
 59. Nurse: that very weak ((shaking head))
 60. hardly survive ((moving hand))
 61. right you want ((pointing down))
 62. your wife and child become like

63. you
64. Patient: → ((shaking head))never seriously
65. → (0.1) ill
66. Nurse: four months (.) when admitted in
67. the provincial hospital after you
68. have already been infected (.) if
69. you
70. Patient: → there (.) there was once

At 34:22 minutes, the nurse asks the patient whether he knows how this infection is spread given that he mentioned marriage in lines 1-4. The patient still provides his explanation that he wishes to be earning before seeking marriage (lines 5-7). However, the nurse tries to delay the patient's thought stating that although the patient may have an income, he should not marry because his infection can be transmitted to his wife. When the patient is told how this disease is transmitted, the patient refers to the use of drugs (lines 16-17). He refers to drugs thereby displaying that he misunderstands that AIDS is curable. The nurse corrects his understanding in the next turn in lines 18-20. The nurse told the patient that although the patient has taken drugs, the virus is still in his body; he is still an AIDS carrier. The patient then refers to condom use in his turn, in line 25. This reference makes the nurse struggle more. However, the nurse corrects him a further time to say that he cannot have a child if he uses a condom. In the next sequences, the patient's revelation comes as a shock to the nurse. The patient told the nurse that he would aim to have a child after a few months with his new wife in stating '[that (.) live for two (.) three months first if we can get married right' as shown in lines 39-41 and 'then try to have a child' in line 43. The nurse's gestures and spoken words show that she recognises the topic is sensitive. The nurse stretches her neck and then produces an exclamation that what the patient is thinking is surprising, stating '((stretching neck)) oh::: no! ((relaxing)) °you are thinking like this° ((smiling)) it is (0.1) quite (.) sca::ry ((nodding))', as shown in lines 44-47. The nurse reminds her patient that he has to recall how he suffered in the past, and that he should not let his new wife and child suffer in the same way. Nevertheless, the patient still resists the nurse's advice. His resistance can be seen in lines 64-65, where the patient told the nurse that he had never experienced serious illness. Then the nurse reminds him about the time of admission to the provincial hospital, but the patient continues to resist by stating that this experience happened only once in the past in line 70, in stating 'there (.)

there was once'. The next sequences show the nurse probes further about the patient's sexual behaviour.

7.15 [10 – 37:08] [VIDEO]

1. Nurse: and until nowadays (2.0) ↑right
2. → ((stretching hand)) >how do help
3. → yourself< (.) if have sexual
4. needs
5. Patient: → no::thing ((shaking head)) [right
6. Nurse: [do not
7. think is it right?
8. Patient: right
9. Nurse: are not ((shaking head)) helping
10. yourself >are not ((shaking
11. → head)) wanking suchlike<
12. Patient: right ((nodding)) just stay
13. ((touching ear))

At 37:08 minutes, the nurse wishes to know how the patient has been conducting his sexual activity. The nurse uses 'help yourself' (lines 2-3). When the patient is then asked whether he has masturbated, he produced a short answer by stating 'no::thing ((shaking head)) [right' in line 5. The patient is adamant in his disconfirmation and denial, and so the nurse uses another technique to probe further, using a repairing technique to clarify what she is talking about. As shown in line 11, she uses the slang word 'wanking' instead of 'masturbation'. This is used when the nurse wants to use less technical language. It can be seen as a technique of downgrading the professional to the local level. The nurse is sceptical about the patient's claim regarding his sexual activity. The next sequences show the nurse again introduces the delicate topic of the spread of infection.

7.16 [10 – 38:18] [VIDEO]

1. Nurse: → but (.) remember ((pointing)) one
2. → thing that (.) if ((showing
3. → fingers)) you sleep with them
4. → (.) your virus((stretching hand))
5. → transmitted to them definitely
6. Patient: right [((nodding))
7. Nurse: [if you do not prevent (.)
8. AIDS carriers ((fluctuating hand))
9. will not have been decreased
10. Patient: right
11. Nurse: if suppose we sleep with many

12. girls (0.1) person who sleeps
 13. with you ((fluctuating hand))
 14. will get infected (.) infected
 15. (.) AIDS carriers increased also
 16. Patient: right ((nodding))
 17. Nurse: nowadays ((moving hand))
 18. ((pointing)) that told you to join
 19. a group (.) to get knowledge
 20. Patient: ((slightly nodding))
 21. Nurse: → so that (.) do not spread
 22. → infection to other people (.)
 23. → you have to ((showing a
 24. → finger)) remember ((pointing))
 25. → the principles of our group.
 26. Patient: right ((nodding))
 27. Nurse: remember
 28. (0.1)
 29. Patient: it if want to be together (.) have
 30. to consult the doctor first
 31. Nurse: uh ((nodding)) that's right (.)
 32. → have to let (.) know first (.)
 33. that who is (.) whether has
 34. already blood †tested

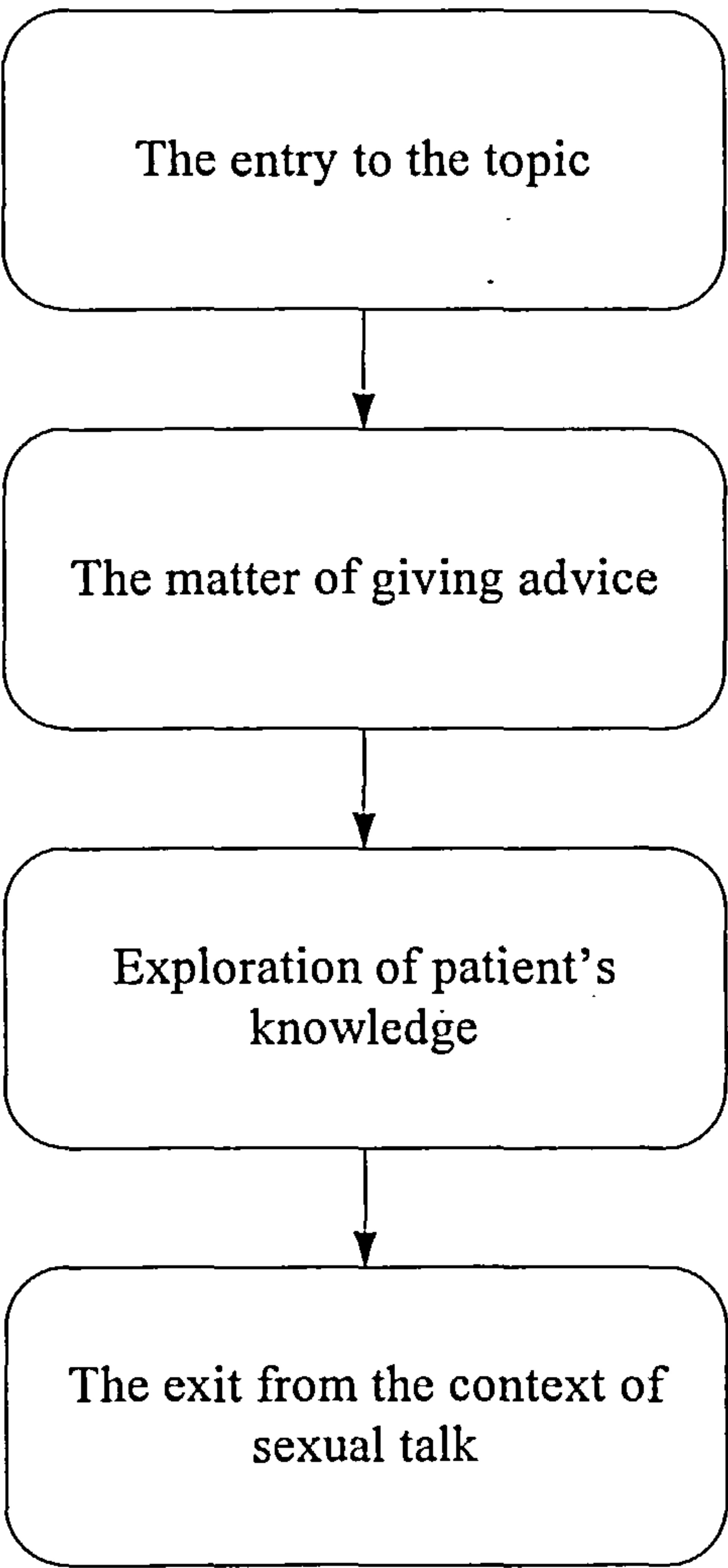
At 38:18 minutes, the nurse re-introduces the topic at the end of the conversation. The way in which the nurse does this is by using an imperative and conditional form to stress that what she is telling her patient is crucial. The nurse states that the patient has to remember one thing, in that if he sleeps with anyone, she will definitely be infected with the virus in lines 1-5. The term 'remember' in line 1, is a word in the imperative form, and the word 'if' in line 2, is a conditional form. Then the nurse reminds the patient regarding the principles of HIV patients' network; the spread of infection is prohibited (lines 21-25). As a member, the patient must not spread infection.

At the end of the context of sexuality, the nurse uses the modal verbs 'have to' before the verb to stress the necessity of her statements in line 32. The nurse advised her patient the patient and his new girlfriend to consult the doctor about marriage. The nurse strongly advises her patient to realize the implications of his actions with respect to the spread of infection and condom use. The nurse has attempted to gain the patient's compliance because the spread of infection is not an acceptable action for counsellors and other people, but the patient has his own accounts for it.⁸²

⁸² In November 2005, I was told by two counsellors that this patient is healthy because he has taken ARVs. His CD4 count was very high. Currently, he was employed. He has planned to do

We can find the pathway of talking about sexuality in the above case. The pathway consists of the entry of the topic, the matter of advice giving, exploration of the patient’s knowledge and the exit from the context of sexual talk as shown in diagram 7. Following the diagram, I illustrate each stage in such pathway in detail. Then, I show cases to underpin what I discuss.

Diagram 7. The pathway of talk on sexuality



7.5.1 The entry to the topic of sexuality

The entry to the topic of sexuality is by both patient and nurse. The patient

what he told the nurse; he made an attempt to find a partner and develop relations for marriage. He still needed to have children. However, no-one was sure whether he would marry another infected person. In the case that he finds someone who is not infected. The next question is whether his new partner will become infected with the virus.

initiates the topic of sexuality simply by implying it. In this manner, the patient suggests to the nurse that she may not know much about the patient's personal life. In doing so, the patient shows his intention to reveal that detail to the counsellor. At this point, the nurse picks up on this revelation and probes further on the topic in the subsequent sequences of talk. Occasionally, the patient directly initiates a matter relevant to sexuality. The data show that one female patient asked her counsellor for male condoms.

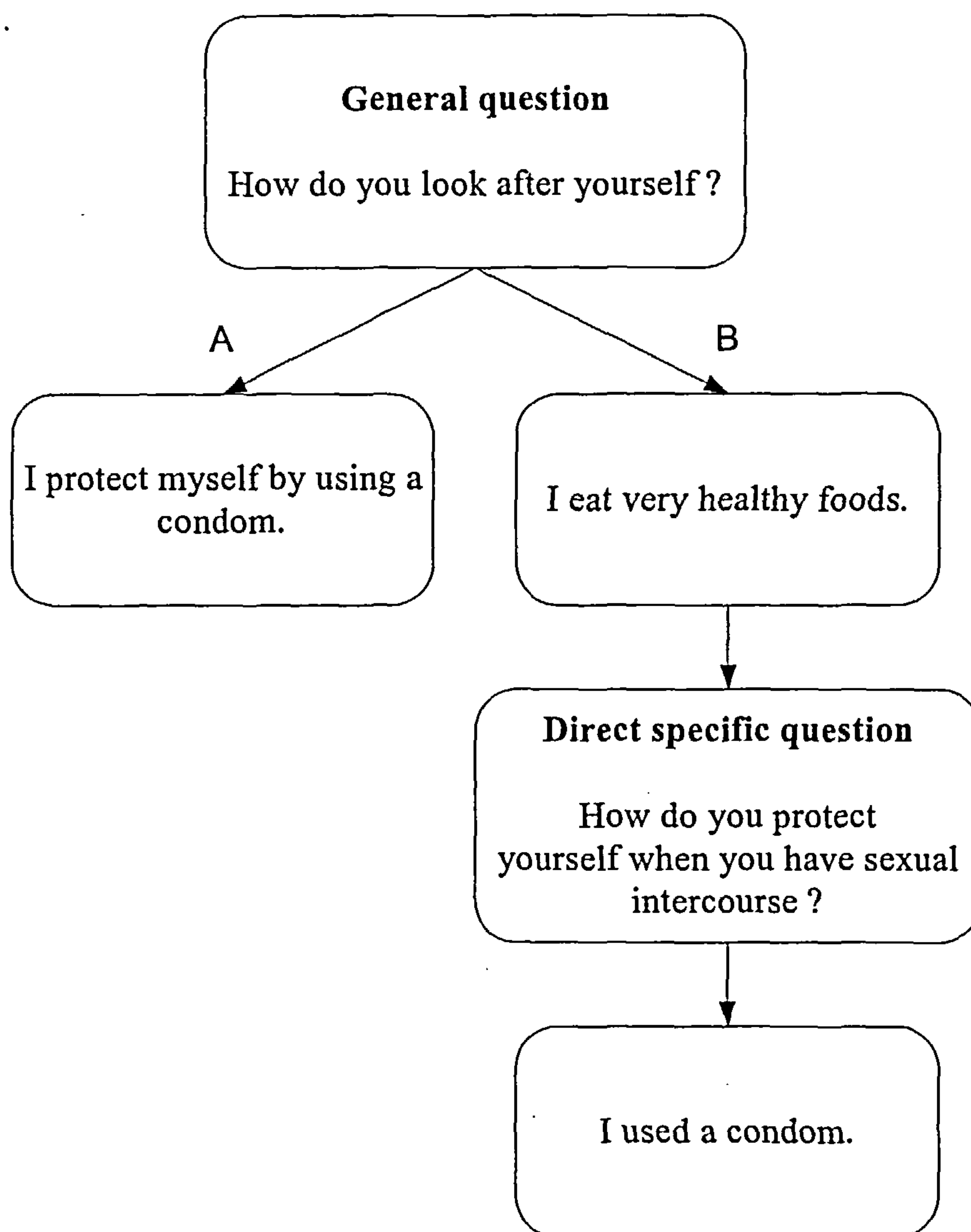
When the topic of sexuality is initiated by the nurse, the nurse employs different types of question to bring it into the discussion. The nurse can initiate the topic of sexuality by talking about the past course of infection of the patient, the patient's sexual partner or the background of the patient. The patient himself may refer to going to a brothel. This can be an important clue for a nurse to discuss the topic of sexuality further. However, the nurse may also open the topic by using a direct specific question, a hypothetical question or an allusive question. These three types of question have been illustrated earlier. In addition, in some cases, the nurse may initiate the conversation on sexuality by using a specific statement.

Occasionally, the nurse may deflect the topic by referring to a third person such as another patient, to raise an issue regarding the health of the patient she is counselling. The nurse refers to some other patient with regard to how that patient improved their strength. She mentions how that patient looks healthy because he or she looks after themselves well or has safe sex or does not take drugs. The nurse mentions how that patient does not get involved with commercial sex work. Reference to and discussion of a third person can smoothly lead the co-participants to address delicate issues.

In some cases, the nurse turns the conversation to the real agenda the nurse wishes to discuss by using a general question. The nurse does not directly address the topic of sexuality, and instead, she and the patient talk about how the patient looks after himself or herself. The nurse normally assesses the first response of the patient, and if she is satisfied with it, she will not probe further. However, if the patient interprets the nurse's question literally, the nurse is sceptical of the patient's initial response or the patient does not respond with what the nurse really needs to know, the nurse moves to another question: a directly specific question. In other words, if the patient does not pick up on the

first question, or does not understand the nurse's intentions or, as the nurse perceives it, dissembles, the patient will be asked another time. At this stage, it is the pursuit of scepticism. The following diagram shows how the nurse finds out what she really wants to know.

Diagram 8. The move from a general question onto a direct question



I should note that in the pursuit of scepticism, the nurse does not expect the patient to tell her the truth, especially about things that are regarded as sensitive or taboo. By pursuing scepticism, the nurse takes on the public health role for which she has to know the patient's sexual conduct. In order to pursue her agenda, the nurse normally assesses the first response of the patient, and if she is

satisfied with it, she will not probe further. The second question clarifies what the nurse means. The diagram 8 shows that the nurse initially uses a general question; for example 'how do you look after yourself'. After this, if the nurse is well-informed as to whether the patient practises safe sex and uses condoms-it is not necessary for the nurse to probe further, as shown in diversion A. However, the nurse may move to a direct specific question, if the patient interprets the question literally and the patient does not respond with what the nurse expects or believes. The nurse clarifies further what she expects to know, and thus the question is quite direct, as shown in diversion B.

7.5.2 The matter of giving advice

My data showed that when the nurse is well-informed in terms of the patient's condom use and sexual behaviour, the nurse normally carries this preventive counselling forward by giving some advice. She will ordinarily advise her patient in terms of safe sex, condom use and sexual intercourse. However, this advice is not found in some cases where the nurse finds it necessary to probe further for information on the patient's sexual behaviour with regard to the spread of infection. In other words, the nurse tends not to give advice at the beginning of sexual talk. In some cases, the counsellor and the patient discuss the advantages of prevention by means of condom use and disclosure of the patient's infection to sexual partners. In addition, the nurse may use non-verbal communication, such as gaze, and other body movements, to establish that the current topic is important and sensitive, or even perhaps related to death. In some cases, the counsellor makes use of Buddhist belief to convince patients regarding the need to avoid spread of infection. Although a patient has themselves been infected, he or she should not spread that infection. The spread of infection may be used as a means for taking revenge, but this kind of revenge can harm a patient, and it should be regarded as a sin.

In this matter, the nurse and the patient discuss not only whether a patient uses a condom or not, but also how a patient uses a condom. In addition, some nurses have made attempts to know whether their patients work in, or get involved with, commercial sex work. The counsellor tries to find out whether the patient has penetrative sex. All these things may put patients into a high-risk

category regarding their sexual behaviour. In this matter, several cases clearly illustrate how the nurse and the patient establish the 'sensitivity' of the subject. The nurse and the patient render the topic sensitive through turn-taking. The data illustrated that the nurse uses intrusive questions, but the way in which she uses them is indirect. In addition, the nurse uses prefaces such as 'uh' or 'then' to address the sensitivity. In addition, an important aspect is the use of non-verbal communication when talking about this sensitive topic. The way in which the nurse uses body movements and gestures, such as the display of nodding and tossing her head, can indicate the sensitivity of the topic. Sometimes, the nurse and the patient use lexical choice, stressed utterances, self-correction and repair to talk about sexuality. In some cases, the nurse produces her statements related to sexuality at a quicker pace than statements on other topics. The way in which the nurse alters or modifies her questions also shapes sexual counselling with regard to its sensitivity. If the nurse is not successful in alluding to what she needs to know, the nurse applies the technique of modifying. The nurse alters questions and assertions until the patient provides the response she is seeking. This can be found in many cases because patients may hesitate or delay in revealing their sensitive stories. When talking about sexuality, the nurse sometimes makes the conversation sensitive by reformulating the next turns of conversation. This kind of technique is used to stress how the topic of sexuality is important and sensitive.

However, my data showed that the nurse tries to find out the problem the patient may have. If there is a problem, the nurse aims to give advice. But in some cases, the patients show that they do not have any problem. This results in their response. They produce an answer which made it difficult for the nurse to achieve her objective in giving advice. Counsellors did not go round difficulties to find space for advice-giving. Instead, they pursued scepticism. This seems to be different from that in Heritage and Sefi's work (1992)⁸³. Heritage and Sefi (1992) showed that health visitors initiated advice-giving no matter how the mothers responded to their inquiries. Health visitors would go round any

⁸³ The work of Heritage and Sefi (1992) with first-time mothers, the clients initiating this issue by requesting advice, is valuable in three important respects. First, it establishes the problem area for which advice is requested; second, it establishes the requester's uncertainty about some aspect of that problem area; third, a request establishes her willingness to receive advice and thereby legitimates the subsequent delivery of advice.

difficulties to give advice. Counsellors in my data pursue continuously what they should know. This makes them modify questions. What the patient told the nurse was not fully truthful. The nurse tried to find what the patient was dissembling or disguising.

7.5.3 Exploration of the patient's knowledge

Third is the exploration of the patient's knowledge. The nurse implements her knowledge in the manner of an educative role. In this feature, the nurse encourage patients to tell how much they know about safe sex or condom use. In other words; the nurse assesses whether the patient implements safe sex. In addition, the patient may be asked to show what he or she knows about how the infection is transmitted or spread. In some cases, the nurse also checks or assesses how much he knows about the relationship between the spread of infection and social responsibility.

7.5.4 The exit from the phrase of sexual talk

Fourth is an exit from the context of sexual talk. The nurse is concerned about safe sex and the spread of infection. The patients are given advice to have safe sex for themselves and their family. However, having safe sex may affect other people who may have contact with the patient. This is relevant to the spread of infection. In this pathway, some particular forms are normally applied in exiting from the context of sexuality; the nurse may use an empathic, persuasive or modified form to exit the conversation on sexuality. The modified form is used when the nurse pursues scepticism.⁸⁴ She modifies questions until she knows what she wants. In some cases, this technique was used until the nurse exits the context. In this stage, counsellors use a modal verb such as 'must' to stress condom use. Some extreme case formulations such as 'every time' are used to stress the safe sex. The nurse may use non-verbal communication such as eye contact and other body movements to emphasise that what she is talking about is important, inevitable and sensitive. For example, a nurse tapped the patient's

⁸⁴ For example, in case no.18 and no.37, there was no issue of giving advice.

hand to seriously restrain the patient from spreading infection.

7.6 Empirical cases

I have worked specifically on some cases in relation to sexual talk. I find it necessary to show these cases in lengthy sequences because different techniques were used to probe into sexual conduct. The nurse did not stop at the first attempt, but came back to discuss it by applying different techniques in further sequences. In addition, the way in which the nurse alludes to sexual conduct reflects not only her role of counsellor, but also their public health role. The nurse seems not to completely believe what the patient told her. Consequently, she assessed what she was informed and pursued it when she was sceptical.

Before I show examples, it should be noted that, some features of the pathway of talk about this delicate issue may be not included in the brief sequences examined. The topic of sexuality may be addressed merely once in an entire conversation. Thus there is no reformulation applied to it as the nurse exits from the context of sexuality and moves into another context of talk. The cases I have chosen to discuss represent the variety of patient types in counselling. These are single male heterosexual patients, single female patients, widows, a couple and male homosexual patients.

Case no. 04

The patient initially revealed his sexual behaviour; he used to be a male prostitute. Throughout the discussion, they discussed the patient's sexual conduct.

7.17 [04 – 08:40] [VIDEO]

[The counsellor was a midwife. This patient was a male homosexual. He used to be involved with commercial sex work in Bangkok. He was not on the ARV programme. He helped his sister run a business. To some extent, his infection affects his business.]

- | | | | |
|----|----------|---|------------------------------------|
| 1. | Patient: | → | pii (the counsellor's name)) (0.1) |
| 2. | | → | do not know detail of mine |
| 3. | | → | ((moving forwards)) ((laughing)) |
| 4. | | → | much ((laughing)) (previously) |

5. → ((leaning a chair))
 6. → [((looking down))⁸⁵
 7. Nurse: → [That's right ((clicking a pen))
 8. → ((writing down)) I would not dare
 9. → to ask
 10. Patient: pii (the counsellor's name))
 11. previously
 12. Nurse: ((looking at patient))
 13. Patient: I used
 14. Nurse: ((putting hands together))
 15. Patient: → ((looking at the counsellor))
 16. → (1.0) ((pointing chest)) I was a
 17. → commercial
 18. Nurse: ((nodding))
 19. Patient: sex worker
 20. Nurse: → ((looking at the patient's face))
 21. → (2.0) ((clicking a pen)) hhh (.)
 22. → ((relaxing)) where did you sell?⁸⁶
 23. Patient: around (the name of the place)
 24. Nurse: ah::
 25. Patient: ((looking down)) sometimes got
 26. three hundred⁸⁷ (.) five hundred
 27. ((looking up)) there was once (.)
 28. got approximately a thousand
 29. Nurse: ((touching the patient's leg)) are
 30. (you) feeling hurt=
 31. Patient: =(no)
 32. Nurse: If have to tell me a story
 33. Patient: yes ((nodding))
 34. Nurse: ((putting hands together))
 35. Patient: I kept it confidential ((pointing
 36. chest))
 37. Nurse: right ((tossing head)) [right
 38. Patient: [there is
 39. only ((showing an index finger))
 40. my sister who has known.
 41. Nurse: uh:: (.) then what did your sister
 42. say? ((relaxing))
 43. Patient: previously (.) sister prohibited
 44. ((tossing))
 45. Nurse: uh:: ((tossing))
 46. Patient: previously I had got lovers (0.5)
 47. about (.) three (.) four lovers
 48. Nurse: ((nodding)) ((nodding))
 49. Patient: they were male ((slightly
 50. nodding)) ((slightly nodding))
 51. Nurse: uh:: ((nodding))

This case shows that the patient initiates the topic of sexuality at 08:40 minutes.

⁸⁵ The patient looks down while telling his story about sexual behaviour until line 14.

⁸⁶ The phrase 'sell the body' in Thai means involvement with commercial sex. The word 'sell' in this context is literally translated. The nurse asked the patient that where he sold his body.

⁸⁷ The patient told the nurse about an amount of money he had got from commercial sex work. The patient refers to the Thai currency unit-the baht. In this context, as shown in line 27, the patient told the nurse that he had obtained three hundred bahts.

The confidentiality of the patient was broken on the basis of the patient's own decision. The data show that the counsellor is considered to be the patient's sole confidant. Thus the patient revealed his background in the past with his counsellor.

The data show that he wishes to reveal something crucial to his counsellor. It should be underlined how the patient is aware of the sensitivity of his story. In revealing his background, he does not tell the whole picture directly. In other words, the patient rendered what he told his counsellor, the fact that he used to be a male prostitute, sensitive. The way in which he made it sensitive and taboo was through interaction in language, using both spoken utterances and gestures. In lines 1-6, the patient initiated the topic stating 'pii (the counsellor's name)) (0.1) do not know detail of mine ((moving forwards)) ((laughing)) much ((laughing)) (previously) ((leaning a chair)) [((looking down))'. The act of moving forwards, laughing and leaning on a chair seems to show that what he is saying is more sensitive.

The counsellor picks up on this and probes further by using a tactic of voluntary elicitation. This tactic is used to offer the patient an opportunity to discuss sexual issues. The counsellor states that she did not dare to ask her patient about his background, shown in lines 7-9. This indicates that if the patient would like to tell her, he can do it voluntarily. The counsellor's tactic is practical in eliciting profound information regarding sexuality. The counsellor is successful because the sexual behaviour of this patient was revealed by the patient himself. The patient told the counsellor that he used to be a male prostitute.

Before the patient revealed that he used to be a male prostitute, he produced a pause by producing a delay lasting up to one second. This patient shows the delay before the revelation of his sexual background in stating '((looking at the counsellor)) (1.0) ((pointing chest)) I was a commercial' in lines 15-17. This pause can be seen to show how this patient is oriented to or knowledgeable about the sensitivity and taboo of his story. He was embarrassed to mention his background.

So far, I should note that some counsellors move their bodies when they have to focus on an issue of sexuality. Patients may produce a pause in conversation and some stretch their body before producing any utterances regarding matters of sexuality. These actions constitute the sensitivity of sexual

issues. It is clear in most of the reviewed counselling cases that patients always produce a pause before any utterances in a first turn of addressing sexuality, and this pause represents delay. This is similar to the finding of Silverman and Peräkylä (1990), who found the use of pause in most counselling sessions in the first observation of talking about sexuality in counselling.

In addition, the use of non-verbal communication shown in the data encourages a comparison with telephone counselling. During the fieldwork, I observed one training session organised by a non-governmental organisation. Participants were trained to be telephone counsellors. During training the participants watched a video showing how to conduct the counselling and they were coached to interpret different characteristics in the voices of callers. Tone, pitch, pause and stress, including crying, were stressed as important during the training. Indeed, they cannot see or capture the non-verbal items such as gaze, body movement or facial expression of patients when they make telephone calls to the counsellors. This may mean that the counsellors have to work harder to understand the real situation of the caller. The data show that the body movements of patients represent their intention. Thus, understanding how they act may indicate something different to what they said.

In lines 20-22, the counsellor co-operates with her patient's action in noting that what the patient is telling her is sensitive. The way in which the counsellor makes it sensitive is that she looked at her patient in the face and breathed out heavily, and relaxed her body before asking the patient where he got involved with this lucrative business. The patient stressed that this story be kept confidential. He delayed referring to it, and he told the counsellor that he has kept his background confidential and there are only a few people who have known about it-only the patient's sister. It is necessary to note that although one's sexual behaviour is sensitive, delicate and confidential, it can be disclosed profoundly, or to some smaller extent, through naturally occurring talk. The following sequences show the counsellor gave the patient advice.

7.18 [04 – 10:46] [VIDEO]

- | | | |
|----|--------|-----------------------------------|
| 1. | Nurse: | understand ((moving hand)) that |
| 2. | | pii (the counsellor's name) asked |
| 3. | | but what I asked ((clasping hands |
| 4. | → | together)) I did not mean (.) you |

5. Patient: ((sniffing))
 6. Nurse: → deserved it
 7. Patient: ((nodding)) ((nodding))
 8. ((relaxing))
 9. Nurse I asked (the patient's name)
 10. (to know) whether (the patient's
 11. name) feel sorry ↑right?
 12. Patient: ((nodding))
 13. Nurse: sorry for ((moving hands)) the
 14. things happened? (0.2) asked (the
 15. patient's name) because for
 16. someone (.) when they did
 17. ((stretching hand)) and
 18. Patient: ((nodding)) ((nodding))
 19. Nurse: negative results ((showing palms
 20. facing flat hands together))
 21. Patient: ((nodding)) ((nodding))
 22. Nurse: they would feel (.) ((---tapping
 23. chest 3 times---)) blame
 24. themselves (.) that we were wrong
 25. → (.) we were wrong wrong wrong when
 26. we thought of it (.) we were
 27. wrong all the time (.) we ((moving
 28. hand)) would not be happy BUT what
 29. you did in the past ((stretching
 30. hand)) and there could have
 31. consequences until nowadays and
 32. ((stretching flat palm of hand))
 33. tomorrow (.) the day after
 34. tomorrow (.)that's our future (.)
 35. all have already been chosen
 36. ((moving flat palm of hand
 37. around)) at that time
 38. Patient: ((nodding)) ((nodding))
 39. Nurse: is it right ↓isn't it?

At 10:46 minutes, the counsellor advises her patient that the past cannot be changed and the patient has to make his future better. The way in which the counsellor gave advice is to use descriptive and affirmative statements. At the beginning of the sequence, the counsellor told the patient when she asked about patient's feeling she did not mean to blame the patient, shown in lines 4, and 6. In giving the patient advice, one aspect that should be demonstrated is that the counsellor uses the technique of listing of threes. The phenomenon of repetition is often found when something needs to be emphasised (see Atkinson, 1984, p.57-73). Jefferson (1990) shows that the list routinely contains three items. In this area, the counsellor repeats and stresses continuously the utterances of 'wrong' three times, as shown in line 25. The counsellor uses this tactic to encourage her patient that he should not blame himself as other people did. In

other words, the counsellor stresses 'do not cry over spilt milk' by using repetition. The patient must walk forwards and make his life better. The following excerpt shows the counsellor has tried to find out how her patient was infected.

7.19 [04 – 16:28] [VIDEO]

1.	Nurse:		uh did not have sex like that
2.	Patient:		ah ((nodding)) ((nodding))
3.	Nurse:	→	but you were around there and have
4.		→	(you) got some ((nodding)) haven't
5.		→	you?
6.	Patient:		((nodding))
7.	Nurse:		yes there was sometimes
8.	Patient:		sometimes ((stretching)) had gone
9.			to thèque got °drunk° (0.1) then
10.			we were pleased (.) then ended up
11.			in bed
12.	Nurse:		uh::
13.	Patient:		((nodding)) ((nodding))
14.	Nurse:	→	((moving forwards)) >did you use a
15.		→	condom mostly?<
16.	Patient:		((nodding)) used
17.	Nurse:		used::
18.			(0.1)
19.	Patient:		mostly I used
20.	Nurse:		((nodding)) that (.) <u>did not use</u>
21.			((showing a flat palm of hand))
22.		→	suppose (.) in life (.) gone to
23.	Patient:		((moving body)) ((sniffing))
24.	Nurse:		in a month (.) met young boys (.)
25.			got three (.) four (.) was there
26.			any once ((nodding)) which (.) did
27.			not use?
28.	Patient:	→	it should be ((nodding))
29.	Nurse:		((nodding)) it should be
30.	Patient:		once ((---nodding 3 times---))
31.	Nurse:		average (.) each month (.) that
32.			did not [use condoms.
33.	Patient:		[where I had gone for fun
34.			once (.) twice

At 16:28 minutes, the counsellor and the patient discussed the patient's background. The patient acknowledged that he sometimes went to a sauna where he had sexual intercourse. The counsellor asked her patient whether he had hunted any sexual partners when he visited commercial sex places as shown in lines 3-5. The patient acknowledged that he had sometimes obtained partners in this manner. Then the counsellor asked him whether he used a condom or not, as shown in lines 14-15. Before the counsellor asked him such a question, she

moved forwards. This question is uttered more quickly than other questions. He confirmed that he had used a condom for sexual intercourse. However the data seem to show that the counsellor did not believe this. Thus the counsellor probed further on what she was sceptical about. She expected to know how often the patient used condoms. She used the utterance 'suppose' as a hypothetical form, in line 22, to know whether there was an occasion where a condom was not used, for example in the case that he had had three to four sexual partners. The counsellor seems to be successful because the patient stated that there were some times where condoms were not used as shown in lines 28. At this stage, the counsellor was provided with information on how her patient was infected to some extent, but the counsellor was not sufficiently clear. In the next sequences, the counsellor makes an attempt to find out further how her patient became infected. The counsellor explores the patient's knowledge regarding the importance of condom use.

7.20 [04 – 19:00] [VIDEO]

- | | | |
|-----|----------|---|
| 1. | Nurse: | is it correct? ((tapping a |
| 2. | | table by a pen)) here (.) this is |
| 3. | | you because you <u>did not use at all</u> |
| 4. | | then (.) <u>how</u> will you know? |
| 5. | Patient: | ((nodding)) |
| 6. | | (0.1) |
| 7. | Nurse: | and this used condoms <u>but not</u> |
| 8. | | always |
| 9. | Patient: | ((slightly nodding)) |
| 10. | Nurse: | and ((looking at the patient)) |
| 11. | | >while staying in Chiangmai |
| 12. | | you had ↑gone often?< |
| 13. | Patient: | ((nodding)) gone |
| 14. | Nurse: | ((nodding)) |
| 15. | Patient: | → but used condoms all the time |
| 16. | Nurse: | used condoms (.) did not forget |
| 17. | | ↑right? |
| 18. | Patient: | ((tossing head)) |
| 19. | Nurse: | → ((slightly shaking head)) did not |
| 20. | | → <u>neglect</u> (.) did not <u>drink</u> |
| 21. | Patient: | ((nodding)) |
| 22. | Nurse: | → so much that [<u>did not use</u> |
| 23. | Patient: | [((nodding)) |
| 24. | | ((nodding)) |

At 19:00 minutes, the counsellor uses some tactics to explore how and what the patient knows about safe sex. In this case, although the patient claimed to use

condoms during sexual intercourse, the counsellor still discusses it in detail to find out whether the patient used them consistently. The counsellor knows that the patient sometimes used condoms. In the past, he stayed in another province and had sexual intercourse with his sexual partner. Thus the counsellor asked him whether he used condoms all the time, in order to know how he was infected. He stated that he used a condom all the time. The term 'all the time' in line 15 is an extreme case formulation. The patient used it in this conversation to stress that he always used condoms. In the next turn the counsellor repeated the question another time by checking whether he consistently used condoms. The counsellor uses the tactic of listing of threes another time. As shown in lines 19-20, and 22, the counsellor constructed the text 'did not neglect, did not drink, and did not use'; these are referred to as a listing of three. The counsellor uses this tactic to make sure that her patient used a condom without neglecting it. The counsellor also ensures that the patient was not so drunk that he forgot to use a condom. The next sequences show the counsellor gives the patient advice.

7.21 [04 – 25:53] [VIDEO]

- | | | |
|-----|----------|---|
| 1. | Nurse: | now you know that (.) ↑where you |
| 2. | | should get infected it is still |
| 3. | | ambiguous that there were a lot of |
| 4. | | experiences in the past ↑right so |
| 5. | | this was not [important. |
| 6. | Patient: | [very promiscuous |
| 7. | Nurse: | not good ((touching the patient's |
| 8. | | → arm)) ((---tapping the patient's |
| 9. | | → arm 9 times---)) ⁸⁸ that blame |
| 10. | | yourself |
| 11. | Patient: | ((laughing)) ((sniffing)) |
| 12. | Nurse: | → <u>because</u> err::pii (the counsellor's |
| 13. | | name) understand (0.1) <u>third gender</u> |
| 14. | | let me use this word |
| 15. | Patient: | ((nodding)) |
| 16. | Nurse: | third gender is (.) easily |
| 17. | | sensitive |
| 18. | Patient: | ((nodding)) |
| 19. | Nurse: | right (.) like |
| 20. | Patient: | ((touching chin)) |
| 21. | Nurse: | a creeper |
| 22. | Patient: | ((nodding)) |
| 23. | Nurse: | when you are close to anybody who |
| 24. | | ((touching chest)) takes care of |
| 25. | | you (.) you will feel that |
| 26. | | ((tapping a patient's arm)) he |

⁸⁸ The patient started smiling, and moving body at 4th tap produced by the nurse.

27. loves you
 28. Patient: ((nodding))
 29. Nurse: you will be ready ((stretching
 30. hand)) to love him and belong to
 31. him
 32. Patient: ((nodding))
 33. Nurse: ((touching the patient's arm)) is
 34. that ↑correct? as pii (the
 35. counsellor's name) saying
 36. Patient: um:: it is ((stretching body)) for
 37. ((shaking head)) someone
 38. Nurse: ((touching chest)) that's right
 39. ((tapping the patient's arm)) when
 40. he looks after you (.) takes care
 41. of you (.) you are ((touching
 42. chest)) ready for ((touching a
 43. → table with a pen)) that's it
 44. → (you) have got 4 (while) pii (the
 45. → counsellor's name) have ((showing
 46. → an index finger)) only one

At 25:53 minutes, before the counsellor and the patient exit the context of sexuality, they discussed in lengthy sequences the past experience of the patient. The patient was encouraged to forget about it. The patient constructs his turn in response to the turn of the counsellor. This shows the use of adjacency pair. The patient constructs an answer when the question is given and he understands what it means. The way in which the patient constructs his turn is the use of self-blaming. He told the counsellor that he had the experience about which he told the counsellor because his behaviour was promiscuous. He was successful because the counsellor responds positively by tapping his arm nine times as shown in lines 8-9. The counsellor supported him in stating that it was not good for him to blame himself. In the next turn, the counsellor shows her orientation to and awareness of the gender issue. She understands the circumstances of homosexuals when they fall in love with someone, starting in line 12. The following sequences show the patient still worries about his secrecy.

7.22 [04 – 31:39] [VIDEO]

1. Nurse: have not hidden
 2. ((touching a patient's arm))
 3. Patient: ↓right ((nodding)) this story
 4. → which (.) I was a commercial sex
 5. → worker ((moving head)) has been
 6. → kept secret through all whole life

At 31:39 minutes, the patient takes his background regarding prostitution to be sensitive. The patient uses a tactic of reformulation in his turn at the end of the conversation to stress that his story was kept confidential through his whole life as shown in lines 4-6.

In summary, the patient voluntarily initiated the topic. This patient revealed his sexual behaviour; he used to get involved with commercial sex work. The counsellor and patient discussed his sexual conduct. The counsellor prepared to exit the context of sexuality, but the patient exited by stressing that his sexual behaviour was kept confidential throughout his life.

Case no. 07

The nurse alludes to the topic of sexuality with a couple. The conversation on condom use and sexual behaviour in this case is very short. The topic is addressed at the beginning of the health consultation. Furthermore, this case shows the use of general questions and specific questions to find out how the HIV-positive couple prevent infection between themselves. The nurse first applies a general question in her turn, but it is not successful. Thus, the nurse moves to a specific question to directly ask her patients about their sexual relations.

7.23 [07 – 01:32] [VIDEO]

[The patients were a couple. Neither patient was on the ARV programme. They had a son who was waiting to have his blood tested.]

- | | | | |
|-----|-----------------|---|------------------------------------|
| 1. | Nurse: | → | then (.) how look after health? |
| 2. | Male patient: | | right |
| 3. | Female patient: | → | right (.) (we) talk between |
| 4. | | → | ourselves (.) then we do not |
| 5. | | → | worry much (.) support each other |
| 6. | Nurse: | | uh |
| 7. | Female patient: | | can eat whatever we want (.) |
| 8. | | | drink milk for health |
| 9. | Nurse: | | uh |
| 10. | Male patient: | | sometimes (.) bought soy bean milk |
| 11. | | | to drink |
| 12. | Nurse: | → | ah (.) which is useful right |
| 13. | Female patient: | | right (.) eat (.) anything which |
| 14. | | | is useful |

The opening of the topic is different from that in the previous case. In this case, the nurse does not apply a euphemistic form of question alluding to sexuality and

instead used a general question (line 1), saying ‘then (.) how look after health?’. Indeed, the nurse expected her patient’s responses to cover areas beyond the issue of health; she seeks information about the patients’ sexual health and life, and whether and how they protected themselves during sexual intercourse; thus, the nurse did not end the line of questioning with only healthy eating. The nurse alludes to their sexual behaviour and find an appropriate tactic to encourage the patients to talk about their sexuality. However, it is clear that neither patient responded with what their counsellor wished to know; the nurse probes further by asking further questions.

Before the nurse moved into a specific question to probe further about their sexual life, the nurse gets involved with a matter of giving advice. Both patients revealed that they did not feel worried; and that they supported each other (lines 3-5). The nurse discussed with them how they ate, but she does not give advice directly because her patients initiate it in terms of reporting what they consumed. The only thing the nurse did in this matter was noting with approval their diet is useful (line 12).

7.24 [07 – 01:56] [VIDEO]

- | | | | |
|-----|-----------------|---|---|
| 1. | Nurse: | → | uh (.) that’s fine (.) and now |
| 2. | | → | when (.) sleep together have |
| 3. | | → | sexual relations (.) how do (you) |
| 4. | | → | prevent? |
| 5. | Male patient: | | wear condoms |
| 6. | Female patient: | | wear condoms ↑right |
| 7. | Nurse: | → | <u>must</u> wear condoms every time (.) |
| 8. | | → | because if wear it every time (.) |
| 9. | | | will not transmit virus to each |
| 10. | | → | other (.) will live with son |
| 11. | | → | longer (.) drink ah drink milk |
| 12. | | | little boy |

A little later, at 01:56 minutes, the nurse asked them how they protected themselves when they had sexual intercourse (lines 1-4). The nurse expected to obtain the right response within the same turn. Thus, she used the tactic of repairing in order to clarify what she would like to know. The nurse uses a self-repairing technique in lines 2-3, by saying ‘sleep together’ and ‘sexual relations’. The nurse uses repair in her turn to clarify what she really means. The nurse wished to know whether they had safe sex or not. The nurse was successful

because both patients revealed that they used condoms. The nurse exited the conversation about condom use by applying an empathic exit. The nurse stressed how the use of condoms was important; if the patients desired to live and stay with their son longer, they had to use condoms. The nurse used the modal verb ‘must’, in line 7, in order to stress that condom use was vital. In the same turn, in lines 7-8, the nurse used an ‘extreme case formulation’ (see Pomerantz, 1986 and Edwards, 2000) to focus on the importance of condom use by producing utterances of ‘every time’. The nurse shaped the counselling by referring to their son, so as to encourage the patients’ condom use. The nurse stated that they would live longer with their son if they used condoms, in lines 10-11. This indicates that the nurse focused on the importance of using condoms by showing the connection between condom use and death, but this was done indirectly.

Case no. 15

The patient had a new sexual partner. This is the reason why the counsellor has to initiate the topic.

7.25 [15 – 26:17] [VIDEO]

[The counsellor was a midwife. The patient was a widow. She was not on the ARV programme.]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | → | (she) does not look like a corpse |
| 2. | | → | (.) now ((pointing)) she is fresh |
| 3. | | → | looking |
| 4. | Patient: | | right ((nodding)) look [nice |
| 5. | Nurse: | | [uh |
| 6. | | | ((nodding)) have (you)((touching |
| 7. | | | the patient's leg)) seen? |
| 8. | Patient: | | seen ((nodding)) ((nodding)) |
| 9. | Nurse: | → | ((moving hand)) take that thing to |
| 10. | | → | ((touching chest)) encourage for |
| 11. | | → | ((touching a patient's leg)) AIDS |
| 12. | | → | carriers (.) in that if we |
| 13. | | → | ((pointing)) do not go (.) to be |
| 14. | | → | promiscuous (.) means that we do |
| 15. | | → | not spread ((pursing hand)) have |
| 16. | | → | not ((moving hands around)) |
| 17. | | → | affairs with men |
| 18. | Patient: | | ((tossing head)) ((tossing head)) |
| 19. | | | right |
| 20. | Nurse: | → | we do not sleep with men (.) we |
| 21. | | → | ((stretching hand)) do not |
| 22. | | → | spread virus to others (0.1) we |
| 23. | | → | ((stretching hand)) are not |
| 24. | | → | commercial sex workers (.)((moving |

25. → hands)) to be honest ((touching a
 26. → patient's leg) we do not stay in a
 27. → brothel
 28. Patient: right
 29. Nurse: to be a girl (.) a prostitute
 30. right like that
 31. Patient: ((nodding)) right (.) right if we
 32. Nurse: are not a prostitute (.) we do not
 33. spread to anybody
 34. Patient: ((nodding))
 35. Nurse: we look after ((raising hand))
 36. ourselves well ((pointing)) live
 37. longer
 38. Patient: ((nodding)) right
 39. Nurse: → like ((counting)) one gets heart
 40. → disease (.) diabetes (.) blood
 41. → pressure
 42. Patient: uh::
 43. Nurse: we ((raising hand)) have medicines
 44. to take all the time
 45. Patient: ((nodding))
 46. Nurse: ((pointing))⁸⁹ take one tablet in
 47. the morning (.) another one in
 48. the evening
 49. Patient: right
 50. Nurse: ((raising hand) in the future (.)
 51. if medicines have been improved
 52. (.) may take ((showing a finger))
 53. them once a day
 54. Patient: ((nodding)) right
 55. Nurse: is it right? (.) or in the future
 56. if your health ((moving hand))
 57. is strong (.) may ((showing two
 58. fingers))⁹⁰ take medicines once a
 59. day (.) or every two days
 60. Patient: ((nodding)) right
 61. Nurse: right (.) it depends on the
 62. [development
 63. Patient: [but:: that (.) I ((raising hand))
 64. stay with this new boyfriend (.)
 65. he ((moving hand)) sometimes
 66. stays with [me
 67. Nurse: [uh uh ((nodding))
 68. Patient: he does not stay all the [time
 69. Nurse: [uh uh
 70. [then
 71. Patient: [you under[stand?
 72. Nurse: [uh ((nodding))
 73. understand (.) that (you) told
 74. boyfriend
 75. Patient: ((raising hand)) he said that
 76. afraid that I thought to be in a
 77. brothel (.) like that like this

⁸⁹ The way in which the nurse is pointing is to show index finger extended from a fist (see Sutton-Spence and Woll, 1999, p.xv).

⁹⁰ The way in which the nurse showed two fingers is by showing a fist with the index and middle fingers extended and spread.

78. ((nodding)) he taught me all
79. Nurse: (uh) (0.1) what did he [teach?
80. Patient: → [but I said
81. → I would not do (.) do not go to be
82. → sex worker (.) like that like this
83. → (.) do not go to be in a brothel
84. → when we first met each other (.)
85. Nurse: ((nodding))

At 26:17 minutes, the counsellor does not open the conversation directly, but she refers to the infection of a third party. The counsellor gives the patient advice on healthy-living by consolidating the importance of taking ARVs and good self-care. The counsellor talks about sexual conduct with her patient by addressing the general issues such as the infection of another patient. In lines 1-3, the counsellor referred to another patient who was better after she took ARVs. She also emphasises that the patient can be healthy if she looks after herself well. The patient should live longer if she does not spread the disease or get involved with commercial sex (lines 9-17 and 20-27). At this point, the counsellor makes an attempt to encourage the patient to have a healthy body by downgrading the severity of AIDS using the technique of a simile. The counsellor compares AIDS with other diseases such as heart disease, diabetes or high blood pressure stating 'like ((counting)) one gets heart disease (.) diabetes (.) blood pressure', shown in lines 39-41. In the next lengthy sequences, the nurse advises the patient about the health benefits from taking ARVs. The patient told the counsellor how she was reminded and helped by her new partner who told the patient not to get involved with commercial sex work. The patient confirms that she would not do so in lines 80-84. The next excerpt shows the counsellor worries about the spread of infection. She is afraid that the infection might be transmitted into the new partner of the patient.

7.26 [15 – 31:14] [VIDEO]

1. Nurse: → ((nodding)) ((nodding)) if he
2. → looks after you (.) that's good
3. → but (.) important [thing
4. Patient: [but I
5. ((nodding))
6. Nurse: → is that (.) must remind him
7. → ((pointing))
8. Patient: ((nodding))
9. Nurse: for condom use
10. Patient: ah:: he understands all

11. Nurse: → uh:: must wear ((moving head)) all
 12. → the time (.) and whenever (.)
 13. → careless or think that it may (.)
 14. → mistake like ((raising hand)) >can
 15. → not unravel a condom<
 16. Patient: ((laughing))
 17. Nurse: → because when (.) wear it ((raising
 18. → hands)) we (.) wear it improperly
 19. → (.) it may be torn at the tip
 20. → ((raising two hands)) at his dick
 21. Patient: ((nodding))
 22. Nurse: or when he takes it off (.) his
 23. hands touch any body fluids from
 24. your vagina
 25. Patient: ((nodding))
 26. Nurse: mucus such like
 27. Patient: ((nodding))
 28. Nurse: if his hands (.) with cuts
 29. something like that we are not
 30. sure
 31. Patient: right
 32. Nurse: → have you ever (0.2) >after
 33. → sleeping together then have ever
 34. → left it in<
 35. Patient: no right
 36. Nurse: no
 37. Patient: right
 38. Nurse: → have (you) slept ((tossing head))
 39. → ((clasping hands together))
 40. → ((suddenly dropping hands))
 41. → together so often?
 42. Patient: no ((slightly shaking head)) do
 43. not often stay together
 44. Nurse: means that ((moving hands)) meet
 45. → each other (.) have sex
 46. → ((stretching hand)) go to sleep
 47. → together (.) go to make love (.)
 48. do it often?
 49. Patient: ((shaking head)) not often
 50. Nurse: not often
 51. Patient: right
 52. Nurse: → how many times a week?
 53. Patient: not a week ((laughing))
 54. → ((showing two fingers))⁹¹ only
 55. → twice a month
 56. Nurse: ah ((nodding)) twice a month
 57. Patient: right seems that (we) are not much
 58. → close sometimes (he) has gone to
 59. → visit (.) just visit right
 60. Nurse: when (he) has gone for visit (.)
 61. ((moving hands) gone every day or
 62. what?
 63. Patient: right (.) visit nearly everyday
 64. but for me (.) sometimes
 65. Nurse: um (.) but do not often sleep

⁹¹ The patient told the nurse that she had sexual intercourse twice a month. While she was saying this, she showed two fingers as the palm back V-sign.

66. together
67. Patient: right ((nodding))
68. Nurse: → if (you) sleep together (.) will
69. → wait until your children slept
70. → already ((moving hands)) or what?
71. → ((touching ear))
72. Patient: → my children ((laughing)) whether
73. → it is dark or not (.) they fall
74. → asleep
75. Nurse: ((tossing head)) ((smiling)) they
76. are still babies
77. Patient: → right still babies

At 31:14 minutes, the counsellor discussed with her patient how the use of condoms was important. This is another occasion where giving advice has been deliberately established. The counsellor starts giving advice. She tells the patient it is important to remind her partner about condom use, in lines 1-3, and 6-7. The counsellor explains that if the patient's new boyfriend used condoms, the virus would not be transmitted from one to the other. In addition, the counsellor instructed her patient as to how the virus was spread, in case her boyfriend did not use condoms properly, in lines 11-15. Her boyfriend could be infected if he had open cuts, for example on his hands, and these touched mucus or body liquids from the patient's vagina in lines 17-20. The counsellor talked about the patient's sexual behaviour in detail. The counsellor explores her patient's knowledge regarding safe sex by asking how the patient and her boyfriend conduct their sexual relations stating 'have you ever (0.2) >after sleeping together then have ever left it in<' in lines 32-34. The patient disclosed that she and her boyfriend had sexual intercourse, but he did not leave his penis inside her vagina when they reached a climax. It is imperative to note that information on sexuality can be alluded to and explored in detail on the basis of talk-in-interaction.

Then the counsellor and the patient focus on the importance of safer sex. Both discussed with sensitivity and directness how the patient had sexual activities with her new boyfriend. It is evident that the delicacy and awkwardness is brought into discussion in natural talk. I demonstrate how the counsellor and the patient are oriented to the sensitivity and delicacy of what they discuss. It is believed that sex is sensitive and taboo. The counsellor has her own techniques to render this topic sensitive. The way in which the counsellor does this must be

elaborated.

First, it is clear, in one turn produced by the counsellor that the topic of sexuality is indicated as sensitive and important by using a modal verb 'must', as shown in line 11. In the same turn in lines 11-12, the counsellor uses 'all the time' as an extreme case formulation. In addition, the counsellor stresses the word 'think' in line 13. Last, in the same turn, the counsellor uses quicker utterances when she mentions the improper way of using a condom. In addition, the use of quicker utterances happened another time in the next turn, as shown in lines 32-34.

Second, the use of a repairing technique by the counsellor can be deemed as oriented to the sensitivity of sexuality. The counsellor uses this technique to clarify what she really means when she talks about sexuality. Sometimes, the counsellor uses three lexical choices in one turn to refer to one particular action. The counsellor clarified to her patient what the utterances 'slept together' in lines 38-41 mean. The counsellor uses a repairing technique in the form of euphemism by producing 'have sex', 'go to sleep together' and 'go to make love' (lines 45-47). These three utterances are referred to in the same context and meaning.

In line 52, the counsellor appears sceptical about how often the patient and her new boyfriend have sexual intercourse, thus she probes further. The patient revealed that they had sex twice a month in lines 54-55. In addition, they had not had sexual intercourse every time her boyfriend visited, in lines 58-59. The data show that the counsellor did not stop here. She asked further as to whether the patient and her boyfriend had had sexual intercourse while her babies were awake (lines 68-71), in stating 'if (you) sleep together (.) will wait until your children slept already ((moving hands)) or what? ((touching ear))'. This kind of question can assure the counsellor whether all the patient's responses are true or not. Whether the patient answers 'yes' or 'no', can indicate how often they had sex. The patient makes sense of what she has been asked, and answers by referring to the fact that her twin babies are still young, and they are always on the bed in lines 72-74 and 77. The following sequences show the counsellor probes the patient's thought on the spread of infection.

7.27 [15 – 34:08] [VIDEO]

1. Patient: → but I (.) not sure whether he will

2.		→	stay ((tossing)) with forever
3.	Nurse:		((waving hand)) do not think
4.			about it
5.	Patient:		do not think ((laughing))
6.	Nurse:	→	if you break up with him
7.		→	((raising hand)) then (.) think
8.		→	in mind for revenge (.) that will
9.		→	((tapping the patient's leg))
10.		→	spread AIDS to him (.) have
11.		→	thought like that?
12.	Patient:		I ((shaking head)) have not
13.			thought right (.) will not do at
14.			all
15.	Nurse:		uh (.) that's good ((moving leg))

At 34:08 minutes, the patient told the counsellor that her partner might not stay with her for good in lines 1-2. The counsellor then asked the patient whether she has any vindictive thoughts in her mind and may take it into account for taking revenge in lines 6-11. The patient told the counsellor that she has not thought of revenge. At this point, the sensitivity of the topic is again referred to. Apart from verbal utterances, the counsellor shows how she is aware of the sensitivity of sexual topics by using body movements. When the counsellor assesses the patient's knowledge regarding the spread of infection, she asks her patient and taps the patient's leg in line 9. This action has been used when the counsellor feels sensitive about discussing something, and wishes to make it less sensitive. The next sequences show the counsellor gives her patient advice.

7.28 [15 – 35:17] [VIDEO]

1.	Nurse:	→	but if one day (.) in the future
2.		→	if he feels bored (.) stay (.)
3.		→	separately
4.	Patient:		((tossing head)) I also [told so
5.	Nurse:	→	[important
6.		→	thing (0.2) uh important thing is
7.		→	that ((stretching hand)) <u>DON'T::</u>
8.		→	get other virus
9.	Patient:		right
10.	Nurse:	→	must use a condom all the time
11.	Patient:		right ((nodding))
12.	Nurse:	→	and as well ((touching patient's
13.		→	leg)) recommend him that if
14.		→	possible (.) pii (patient's
15.		→	boyfriend) go to have blood test
16.		→	take him along on Thursday
17.	Patient:		I think [so
18.	Nurse:		[I will do it for him
19.			((touching patient's leg with
20.			right hand)) having blood test

21. does not mean ((showing clawed
 22. hand)) to find his something wrong
 23. or something like that
 24. Patient: right
 25. Nurse: → ((putting arms)) but we
 26. → help (.) prevent him
 27. Patient: → ((scratching)) ((looking up))
 28. → while staying with me (.)
 29. → previously I told him to have
 30. → blood test ((moving hand)) he said
 31. → that he had had already blood test
 32. → (.) I said that in the future
 33. → ((raising hand)) if he got
 34. → infected ((raising hand)) he could
 35. → not blame me for transmission
 36. Nurse: uh (((tossing head))
 37. Patient: [not sure (.) have to (.) for
 38. blood test before staying with me
 39. Nurse: ((nodding)) correct
 40. Patient: he said that he had blood test (.)
 41. but nothing
 42. Nurse: uh ((tossing head))
 43. Patient: if ((raising hand)) been infected
 44. then ((moving hand)) do not blame
 45. → me (0.2) but I think (0.2) he has
 46. → not had blood test yet

At 35:17 minutes, the counsellor recommends to her patient that although her boyfriend might not stay with her in the future or she may break up the relationship with him, she still has to use a condom for safe sex in lines 1-3, and 5-8. The counsellor stresses and stretches the word 'DON'T::' in line 7. Moreover, she makes it louder in order to underline how crucial it is that the patient not contract other viruses. In line 10, the counsellor stresses the importance of condom use by using a technique of extreme case formulation; the counsellor uses 'all the time'. In addition, the counsellor recommended that her patient convince her boyfriend to have a blood test (lines 12-16). The counsellor told the patient that doing so will protect him and enable him to know if he is still negative in lines 25-26. At the end of the sequences, the patient told the counsellor that she used to tell her partner to have a blood test because she was afraid of being blamed if her partner was infected in lines 27-35. However, the patient was sure that her partner had not had his blood tested in lines 45-46. Here, I should note that whilst the counsellor wishes to prevent the patient's partner from being infected, the patient also protects herself from blame. In the next sequences, the counsellor used the empathic exit to point out to her patient that

the use of condoms was vital.

7.29 [15 – 36:37] [VIDEO]

1. Nurse: → AND (0.2) do not forget that I
2. → told (.) that do not ((counting))
3. → get another virus right
4. Patient: ((tossing head)) right

The above excerpt shows the counsellor instructed her patient to remember the advice given. The counsellor emphasized that the patient must not contract another virus. Furthermore, the excerpt is an illustration of the sensitivity and delicateness of the topic. The counsellor illustrates how she considers the talk sensitive by reformulating it at the end of the conversation. The counsellor normally uses the reformulation at the empathic exit of a conversation. The way in which the counsellor uses empathy is by using the stress 'AND' and imperative forms 'do not forget' and 'do not get another virus' in lines 1-3. It has been used to stress a further time that the patient must not forget what she has just been told, and the patient must not get another virus.

In summary, both participants discuss sexuality and make sense of what the nurse really wishes the patient to do. The counsellor encouraged the patient to convince her new boyfriend to use condoms and have a blood test. The counsellor also advised the patient not to get involved with commercial sex work. The patient was told to regard the spread of infection as 'bad revenge'.

Case no. 18

The subsequent example shows how the counsellor pursues their scepticism. The counsellor alludes to the spread of infection and sexual conduct by modifying different questions.

7.30 [18 – 03:36] [VIDEO]

[The counsellor was a midwife. The patient was single. He was on the ARV programme.]

1. Nurse: ((writing)) and (you) have
2. known ((turning to patient))
3. ((clasping hands together))
4. → >when have you been infected?<
5. Patient: ((looking up)) when-
6. Nurse: how many years ago?

7. Patient ((smiling)) (0.2) year (0.1) in
8. 1::::99:::5
9. Nurse: ((writing))
10. Patient: 95
11. Nurse: ((writing)) uh ((looking at
12. patient)) uh
13. Patient: → that (I) went for blood test
14. Nurse: uh (.) ((putting hands together))
15. → WHY DID GO to have blood test?
16. Patient: suspected ((nodding)) that (I)
17. was at risk
18. Nurse: ((nodding)) ((nodding)) (0.3) how
19. risk?
20. Patient: → gone for girls ((touching the
21. table)) at local restaurants

At 03:06 minutes, the counsellor introduced the topic by asking about the patient's infection, in stating '>when have you been infected?<' as shown in line 4. The patient stated that he was infected through sexual intercourse, but this is not clear at first. The patient's statement provides an important clue for the counsellor to probe further about his sexual behaviour. The counsellor picked up on this: in line 13 the patient revealed that he went for blood test and in line 15, the counsellor asked the patient 'WHY DID GO to have blood test?'. This question enables the counsellor to know that the patient felt himself to be at risk, and the patient revealed his sexual behaviour as shown in lines 20-21. The patients stated that he went for girls at a local restaurant. This feature of talking about his infection is referred to as a general address, which enables the counsellor to pursue the matter of his sexual conduct. The next sequences show discussion on the spread of infection. The nurse takes on a public health role. She then wishes to know whether the patient spreads infection or not.

7.31 [18 – 08:26] [VIDEO]

1. Nurse: → when ((tapping the patient's leg))
2. → you knew (.) in 199:5 (.) knew
3. → ((touching neck)) yourself
4. → infected ((turning to the
5. patient)) have gone (.) >spread
6. → infection haven't you?<
7. Patient: → no ((shaking head))
8. Nurse: gone for the girls ((moving head))
9. Patient: no
10. Nurse: gone for ((stretching
11. hand)) whores
12. Patient: ((shaking head)) no (.) stopped
13. [already

14. Nurse: [any (.) brothel ((stretching
15. hand)) suchlike
16. Patient: no ((looking down)) have not gone
17. [at all
18. Nurse: [ah::
19. Patient: completely stop
20. Nurse: → ((moving body forwards)) uh >WHEN
21. → NEED IT HOW TO DO< ((touching
22. → arm)) (1.0) need sex ((moving
23. → hand))
24. Patient: → do not know ((shaking head))
25. → ((smiling))
26. Nurse: → or have (you) ever helped yourself
27. → haven't you? (0.1)
28. → wan[king ((moving hand))
29. Patient: [have sometimes [have also
30. Nurse: [((nodding))
31. (0.1) often?
32. Patient: ((shaking head))
33. Nurse: but for girls ((shaking head))
34. haven't gone
35. Patient: haven't gone
36. Nurse: why haven't (you) gone? ((looking
37. out))
38. Patient: afraid that (.) would be getting
39. worse (.)
40. Nurse: uh
41. Patient: ((moving hand)) afraid that
42. ((smiling)) would get more
43. Nurse: → uh ((nodding)) >EVEN use a condom<
44. → (.) haven't ? ((shaking head))
45. Patient: → no ((shaking head))
46. Nurse: → no (.) ((shaking head)) are not
47. → brave to do [that ↑right?
48. Patient: [no (.) not brave
49. to do
50. Nurse: → ((writing)) (0.3) after having
51. → known (.) never [gone ↑right?
52. Patient: [no (.) haven't
53. gone
54. (0.3)
55. Nurse: → ((clasping hands together)) and
56. → ((turning to patient)) >how about
57. → normal girls next door<
58. Patient: no ((shaking head))
59. Nurse: no
60. Patient: no ((shaking head)) even girls
61. next door
62. Nurse: ((nodding)) no
63. Patient: that's why (I) am not staying
64. [nearby
65. Nurse: [about life nowadays

In the above sequences the counsellor suspects that the patient may have spread infection. Thus the counsellor asked him by stating 'when ((tapping the patient's leg)) you knew (.) in 199:5 (.) knew ((touching neck)) yourself infected ((turning

to the patient)) have gone (.) >spread infection haven't you?<' in lines 1-6. The patient provided his counsellor with a short answer in line 7, stating 'no ((shaking head))'. Consequently, the counsellor uses another technique to probe further. The technique used by the counsellor is referred to as a modified technique. It is important to point out its characteristics, and that is that several questions regarding sexuality are put to the patient until the counsellor receives the responses she is seeking. The counsellor changes the form of question several times, but each must have the same meaning. This technique is typically used by most counsellors. The counsellor asked the patient what he did if he desired sexual affairs, as shown in lines 20-23, stating '((moving body forwards)) uh >WHEN NEED IT HOW TO DO< ((touching arm)) (1.0) need sex ((moving hand))'. The counsellor produced quicker and louder utterances to address sexuality. In the next turn, the patient produced an evasive answer a second time, as shown in lines 24-25 stating 'do not know ((shaking head)) ((smiling))'.

At this stage, his response makes it difficult for the counsellor to proceed in the direction she is aiming for. Thus, the counsellor used a repairing tactic and a slang word 'wanking', in her next turn to know what the patient did for sexual pleasure. The counsellor asked 'or have (you) ever helped yourself haven't you? (0.1) wan[king] ((moving hand))' in lines 26-28. The counsellor was then provided with information on how her patient improved his sex life. In addition, the counsellor assessed whether her patient went to buy sex at a brothel. At this stage, the counsellor uses an exploration of the patient's knowledge regarding sexuality and infection.

The patient told the counsellor that he did not go to a brothel because he was afraid of getting worse if he went to the brothel for sexual intercourse. This indicates to some extent that the patient has knowledge that HIV patients can become more ill if they have sexual intercourse without using a condom because another kind of virus may harm the patient's body.

Although the counsellor was well-informed as to why the patient did not go to the brothel, the counsellor continued to use the modified technique. This indicates that the counsellor was not convinced. As shown in lines 43-44, the counsellor altered the patient's response in that the patient did not go to the brothel at all, even though he could use condoms. The patient still confirmed his previous claim by producing the same response, producing a blocking answer by

stating 'no ((shaking head))' in line 45. His blocking answer makes it difficult for the counsellor to probe further. The counsellor then modified his assertions further in her next turn in lines 46-47, 50-51, and 55-57. I should note that in this case, the counsellor has conducted a pursuit of scepticism. At this stage, the counsellor exits the context of sexuality by modifying the assertions of the patients until she obtained what she was seeking. The patient did not have sexual intercourse, even with girls who lived in the same community.

In summary, the counsellor did not give the patient advice. Instead she pursued scepticism on whether the patient had gone to a brothel or not. In addition, the counsellor reserved a public health role. She did not expect the patient was telling her everything. The counsellor pursued what she believed the patient was dissembling by modifying questions.

Case no. 37

This case also illustrates the pursuit of scepticism. The counsellor introduced the discussion indirectly. The counsellor tried to find the truth whether the patient went to buy sex and had safe sex or not.

7.32 [37 – 08:18] [VIDEO]

[The counsellor was a midwife. The male patient was Laotian. He worked in Thailand. He was not on the ARV programme.]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | | right (.) when (you) stay alone |
| 2. | | → | ((tossing head)) gone for ↑girls? |
| 3. | Patient: | | ((touching shoulder)) never (.) |
| 4. | | | [at all |
| 5. | Nurse: | → | [brothel (.) next to that |
| 6. | Patient: | → | no::: |
| 7. | Nurse: | → | brothel (.) Ban Mai (.) also |
| 8. | | | [over there |
| 9. | Patient: | | [I (.) since divorced |
| 10. | | | ((pointing)) divorced (.) that |
| 11. | | | wife (.) (the name of the |
| 12. | | | patient's wife) right |
| 13. | Nurse: | | right (.) right |
| 14. | Patient: | → | gone once |
| 15. | Nurse: | | gone girls at Ban Mai ↑right |
| 16. | | | ((nodding)) |
| 17. | Patient: | | right ((nodding)) |
| 18. | Nurse: | | went to that brothel ↑right |
| 19. | Patient: | | right (.) visited (.) at that time |
| 20. | | → | (.) wore double cases |
| 21. | Nurse: | | wore double cases |
| 22. | Patient: | | to be honest ((smiling)) |

23. ((touching table))
 24. Nurse: drunk and went there ((smiling))
 25. Patient: did not drink ((shaking head))
 26. Nurse: went (.) because really needed
 27. going like that
 28. Patient: → right (.) gone ((showing an index
 29. → finger)) ONLY ONCE (.)
 30. → that time
 31. Nurse: er: (.) after going (.) had
 32. (you) thought ↑much ((stretching
 33. hand))
 34. Patient: did not think anything ((shaking
 35. head))
 36. Nurse: because ((moving hands)) you wore
 37. condoms
 38. Patient: right ((nodding))
 39. Nurse: → uh (.) sure that ((nodding))
 40. → yourself (.) wore it properly?
 41. Patient: ((nodding)) right

At 08:18 minutes, the counsellor desired to know whether her Laotian patient had safe sex or not. The counsellor did not ask him a question directly. One technique applied to the entry of sexual talk is to use a euphemistic form of question. In line 2, the counsellor produced ‘gone for ↑girls?’⁹² as a euphemistic utterance. In the past, these utterances were used to refer to men who had gone out to see women and approached or courted those women for their girlfriends or wives. Use of this phrase can be found in most northern rural areas, and this phrase is still currently used, so it keeps the same meaning. In some areas, it is used to refer to when men have gone to buy sex at brothels. In the context of HIV counselling, this kind of utterance is used to refer to when patients have gone to a brothel for commercial sex. In this example, it is not clear what this euphemistic question means at the beginning. It becomes clear that it means the patient going to the brothel (line 5), where the counsellor states ‘[brothel (.) next to that’. Initially when the counsellor asked her patient whether he went to the brothel, he produced a short answer in line 6, in stating ‘no:::’. The counsellor then probes further by specifying the name of the brothel she is referring to, (line 7). However, before the patient acknowledged that he was a brothel-goer, the patient uses the technique of self-correction, but not directly. He made an attempt to find

⁹² The word ‘gone for girls’ in this context means going to a brothel. It is rather difficult to find an appropriate English word to literally describe the phrase in Thai. In Thai, this word means travel or going somewhere to have fun. As shown on the video, these northern utterances are ไปเที่ยว.

appropriate reasons as to why he had to go to the brothel. He revealed that since he got divorced from his wife, he went to that brothel once (line 14), and he used double condoms (line 20). The patient's account for going to the brothel and buying sex may be regarded as a defensive action. In the next turn, the way in which the patient used self-correction is evident. I should remark that the patient feels his statement to be more reasonable by making the claim about the number of condoms he wore. At this stage, the discussion is referred to as a pursuit of scepticism and an exploration of the patient's knowledge. The counsellor probes further whether this patient understands safe sex correctly. The way he explained his use of condoms shows a lexical choice. He referred to 'cases', which means condoms. The patient still makes his claim reasonable. The way in which he did it was by showing an index finger, and stressing it louder, stating 'right (.) gone ((showing an index finger)) ONLY ONCE (.) that time' (lines 28-30). The statement that he used double condoms⁹³ causes the counsellor to probe further. In the theory of HIV counselling, wearing several condoms at the same time is seriously prohibited. This is because it may cause leakage. Thus, in the next turns, the counsellor asks her patient more questions to make sure that he understood well about condom use. As shown in lines 39-40, the counsellor repeats her questioning as to whether the patient used condoms properly or not. This is an exploration of the patient's knowledge regarding condom use. In the next sequences, the counsellor did not follow up about his sexual behaviour because she was provided with adequate information about how the patient became infected. He revealed that his wife infected him with the virus. The counsellor used the modified technique to exit the talk. She altered the way of asking until she was provided with what she is seeking.

The case illustrated how the counsellor modified questions to find the patient's sexual conduct. There was no matter of giving advice. The counsellor tried to find whether the patient had any problems in terms of sexual conduct. But the patient produced answers which made it difficult for the counsellor to probe further including giving advice. Throughout their conversation, the counsellor pursued scepticism.

⁹³ I consider that case is the most appropriate word for this context. Thus I used it in my English transcript. In Thai conversation, the patient used case to mean condom. In Thai, this utterance is คาส. This word means something used for covering.

Case no. 43

This case shows a midwife talking to a male homosexual patient who took a passive role in sexual relations. His sexual behaviour was considered promiscuous, and he had had several sexual partners. In Thailand, as in some other places, men who have sex with men and homosexuality is still an issue that is not discussed openly. However, men who have sex with men are regarded as a group at risk. This case is considered abnormal because the patient seems to be very forward when engaging in talk. In addition, he looks professional in hiding his infection. He provides his own account for having unsafe sex which is rather different from those provided by other patients. The following sequences show the entry of the topic.

7.33 [43 – 00:38] [VIDEO]

[The counsellor was a midwife. The patient was a homosexual male patient. He was not on the ARV programme. He passed away after the researcher left the research site.]

- | | | | |
|-----|----------|---|---|
| 1. | Nurse: | → | uh ((tossing head)) then today |
| 2. | | → | (you) said ((clicking a pen)) ⁹⁴ |
| 3. | | → | that have got anything to tell |
| 4. | Patient: | | have not got anything (.) I do not |
| 5. | | | know ((touching face)) oh::: I do |
| 6. | | | worry right |
| 7. | Nurse: | | ((tossing)) ah worry about what? |
| 8. | Patient: | | that::: (0.3) there was (.) out |
| 9. | | | of control ((laughing)) |
| 10. | Nurse: | → | what (.) I taught (you) could not |
| 11. | | → | follow at all (.) <u>even one</u> |
| 12. | | | ((smiling)) |
| 13. | Patient: | → | you taught (.) (I) also realised |
| 14. | | → | (.) sometimes (.) how was it ? |
| 15. | | → | ((looking down)) ((moving |
| 16. | | → | hands))it was that ((winking right |
| 17. | | → | eye)) there were some in hands |
| 18. | | → | (0.1) it was not enough::: anyway |
| 19. | | → | ((moving hand)) |

The above excerpt has many interesting features. The counsellor discussed the topic of sexuality, in relation to the spread of infection, by using a unique tactic. The counsellor picks up on what the patient needs to tell the counsellor and initiates the topic by offering her patient an invitation, stating that the patient has something to voluntarily tell her (lines 1-3).

⁹⁴ The nurse continuously clicked a pen until line 19.

The counsellor then employs another tactic in her next turn, which should be examined further. The counsellor blames her patient for his actions in the sense that he did not follow advice she gave in the last counselling session as shown in lines 10-11. This tactic can be regarded as practical because it encourages the co-participants to discuss further, and in detail, the sexual behaviour of the patient. The patient shows how he makes sense of the counsellor's turn by replying that he did listen to her advice, but that sometimes it was difficult to consider the use of a condom every time as shown in lines 13-19. His sexual behaviour is as it is because the patient does not have anyone whom he considers as a real love. The counsellor and patient then discussed the relationship between love and passion as shown in the following sequences.

7.34 [43 – 03:53] [VIDEO]

- | | | | |
|-----|----------|---|--|
| 1. | Nurse: | → | ((showing index fingers of two |
| 2. | | → | hands)) ⁹⁵ if (.) distinguish |
| 3. | | → | between the human love (.) if love |
| 4. | | → | between |
| 5. | Patient: | | ((nodding)) |
| 6. | Nurse: | | human beings to each other |
| 7. | | | ((moving one index finger around |
| 8. | | | another)) |
| 9. | Patient: | | ((nodding)) |
| 10. | Nurse: | | it is one kind of love |
| 11. | Patient: | | ((nodding)) |
| 12. | Nurse: | | the natural love |
| 13. | Patient: | | ((nodding)) |
| 14. | Nurse: | | like woman and man |
| 15. | Patient: | | ((nodding)) |
| 16. | Nurse: | → | it is the love ((separating |
| 17. | | → | hands)) based on understanding |
| 18. | Patient: | | ((nodding)) |
| 19. | Nurse: | | there is warmth |
| 20. | Patient: | | ((nodding)) |
| 21. | Nurse: | | there is need (0.1) to build up |
| 22. | | | a mutual future |
| 23. | Patient: | | ((nodding)) |
| 24. | Nurse: | | together |
| 25. | Patient: | | ((nodding)) |
| 26. | Nurse: | | but ((stretching a hand towards |
| 27. | | | a patient)) as (I) listened you |
| 28. | | | told right |
| 29. | Patient: | | ((nodding)) |
| 30. | Nurse: | → | it ((waving)) is not ((clasping |
| 31. | | → | hands together)) your one is (0.1) |
| 32. | | → | superficial (.) it is seeking for |

⁹⁵ The way in which the nurse is showing this is to show index fingers extended, pointing forward. The two index fingers are moved nearly into contact with each other.

33. → (.) seeking for happiness (.)
 34. → seeking for warmth
 35. Patient: ((running hand through hair))

At 03:53, the counsellor gives her patient further advice about the matter of love as shown in lines 1-4. The counsellor distinguishes between love and passion. True love should be built up based on understanding (lines 16-17). In addition, love is involved with warmth. By contrast, the counsellor underlined that what the patient is experiencing is passion in lines 30-34. The counsellor apparently reserves for herself an educative role. She initiates the giving of advice many times, without requesting any advice from her patient. The following sequences show the patient reformulates the topic of his sexual behaviour another time. He told the counsellor about how he had sexual affairs with many sexual partners.

7.35 [43 – 17:45] [VIDEO]

1. Patient: → err (.) did I tell you anything?
 2. Nurse: that-
 3. Patient: am not telling (.) not good right
 4. ((smiling))
 5. Nurse: what happened? tell me
 6. Patient: that
 7. Nurse: as (I) heard (.) it was
 8. [no that ((drinking coffee))
 9. Patient: (((laughing)) ((wiping face)) came
 10. back from ((retracting hands
 11. down)) Chiangmai then to Lampang
 12. and here
 13. Nurse: ((putting cup on the table)) uh
 14. Patient: all friends
 15. Nurse: (what time did you arrive?)
 16. Patient: had already (.) gone back (.) took
 17. a bus to Vieng⁹⁶ ((touching a
 18. table))
 19. Nurse: ((tossing head))
 20. Patient: I slept (.) and the bus passed by
 21. Nurse: ((tossing head)) ((tossing head))
 22. Patient: → then ((touching face)) I sat
 23. → facing them drinking (.) I did not
 24. → know them (.) all young men
 25. → ((touching eye lid) I sat alone
 26. → there was one young boy walking to
 27. → (.) in group ((showing three
 28. → fingers))⁹⁷ there were totally
 29. → three

⁹⁶ The word 'vieng' in this context means the city centre of each district.

⁹⁷ The way in which the patient is showing three fingers is to show an index finger, middle finger and ring finger extended and spread.

At 17:45 minutes, the counsellor and the patient discuss sexual behaviour and more specifically the spread of infection. The patient initially revealed how he had recently spread infection. The way in which he initiated it was to use a preface in his turn. He produces 'err', which is the same as using 'well' in English at the beginning of the turn in line 1. Then he continued with a question as to whether he told the counsellor or not about what he had done. One critical aspect, which is universally found, is that both the counsellor and patient do not talk directly about sexual matters from the outset. They always produce a preface first. This action is normally used for a topic change in conversation. In terms of sexuality, it is also used to begin the context, which is considered sensitive according to Thai social structure. In Thai society it is difficult for people to initiate the topic of sexuality with senior people or someone who is of superior status in a very intimate matter. Similarly, as in many other cultures, talk about sex is normally not conducted publicly. The patient revealed that he met three young guys on his way home (lines 22-29). One of the men approached the patient and caused him to become aroused. The next sequences show that the patient had unsafe sex with many sexual partners.

7.36 [43 – 18:48] [VIDEO]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Patient: | → | ((touching face)) he said that he |
| 2. | | → | would get condoms ((laughing)) |
| 3. | Nurse: | | ((tossing)) |
| 4. | Patient: | → | indeed told others (.) came (.) |
| 5. | | → | did not count if counted (.) |
| 6. | | → | ((running hand through hair)) |
| 7. | | → | approximately ten (.) I was alone |
| 8. | Nurse: | | ((tossing)) (0.2) uh (0.1) had |
| 9. | | | something together ↑right? (.) uh |
| 10. | Patient: | | uh |
| 11. | Nurse: | | uh |
| 12. | Patient: | | uh (.) I said (.) I could not (.) |
| 13. | | | very old |
| 14. | Nurse: | | ((tossing)) |
| 15. | Patient: | | so weak (.) could not (.) very old |
| 16. | | → | (.) just imagine only two (.) |
| 17. | | → | three condoms |
| 18. | Nurse: | | uh ((tossing)) |
| 19. | Patient: | → | there were many people (.) would |
| 20. | | → | take turn to use (.) it was |
| 21. | | → | impossible |
| 22. | Nurse: | | ((moving backwards)) ((leaning a |
| 23. | | | chair)) uh |
| 24. | | | (0.2) |
| 25. | Patient: | | said 'no no no' (.) told them |

26. (.) whether they would wear
 27. condoms or not (.) there was three
 28. condoms (.) I thought (.) it did
 29. → not matter (.) impossible (.) had
 30. → to be infected (.) I said right
 31. → (.) had to be infected
 32. Nurse: ((slightly moving right hand))
 33. Patient: they said that time (.) did not
 34. think
 35. Nurse: ((touching chin))
 36. Patient: about anything at all (.) ha (.)
 37. how could that be (.) did not
 38. think (.) whole life (.) feared
 39. death (.) if I did not fear (.) if
 40. they did not fear (.) if you don't
 41. fear (.) I do not either (.) I was
 42. a bit annoyed ((smiling)) ha I
 43. said (.) well (.) you like a
 44. challenge (.) I like more
 45. challenge (.) then (.) you will
 46. see the hell:: exists ((laughing))
 47. → they did not listen (0.1) if I
 48. → revealed directly that I have been
 49. → infected (.) they ((moving hand))
 50. → would tell others (.) friends
 51. → would know more ((putting hand on
 52. → the table)) that's why (.) I did
 53. → not tell the truth ((moving
 54. → hand))
 55. Nurse: → ah ((raising hand))⁹⁸ then (.)
 56. → did you know ((moving hand)) who
 57. → those young boys are?
 58. Patient: → Ban Suan Hom (.) all the gang
 59. Nurse: ((suddenly dropping hand))
 60. Patient: ((laughing)) Ban Suan Hom filed
 61. Nurse: ((tossing))
 62. Patient: behind what? (0.1) behind shop of
 63. Poo Sia
 64. Nurse: → ((facial expression))⁹⁹((tossing))
 65. Patient: ((laughing)) there is a small
 66. department store there
 67. (5.0)
 68. Nurse: → ((shaking head)) °whose sons
 69. → have not known°

At 18:48 minutes, the patient told the counsellor that one of his sexual partners told him that he would go and fetch some condoms as shown in lines 1-2. Indeed, it appeared he had gone to tell more partners to join in. The patient stated that he did not count exactly how many partners participated in that sexual activity. He could estimate roughly that there were partners up to ten participants, as shown in

⁹⁸ The nurse raises the right hand and keeps it frozen until the patient finishes his turn in line 57.

⁹⁹ See more details about body movements in Bull (1983) and Sutton-Spence and Woll (1999).

lines 4-7. He revealed that he had sexual intercourse with many young male sexual partners. In other words, he had a gang-bang (Ayto, 2003, p.77).¹⁰⁰ He confessed that the lack of condoms precludes any prevention. He told the counsellor that it was difficult to use condoms because there were not sufficient as shown in lines 16-17. It was impossible to take turns using condoms as shown in lines 19-21, consequently some of his sexual partners did not use a condom. At this stage, the data show that the patient realised that some partners had to be infected as shown in lines 29-31. He revealed that he could not tell anybody there about his infection as shown in lines 47-54 stating ‘...they did not listen (0.1) if I revealed directly that I have been infected (.) they ((moving hand)) would tell others (.) friends would know more ((putting hand on the table)) that’s why (.) I did not tell the truth ((moving hand))’. At this point, the counsellor probed further as she is sceptical about what she was told. The counsellor sought reassurance on whether her patient exaggerated his activities. Thus, the counsellor selected some particular issues on which to probe further. In this area, the counsellor expected to know who his victims are. Thus, the counsellor asked directly in her next turns, as shown in lines 55-57 by asking who they were and where they were living. The counsellor produced these utterances continuously, without any gap, between them and the prior turn of the patient.

At this point, there is another feature that should be pointed out. It is the way in which the counsellor takes the story told by this patient as sensitive, dangerous and unacceptable. The counsellor asked her patient whether or not he knows where these young boys are residing. After the counsellor is told about it, she drops her hand suddenly in line 58. This action is correlated to the fact that she seems to be scared and angry. At this point, the counsellor shows her feeling through facial expression as shown in line 64. This kind of action seems to show the anger of the counsellor as described by Bull (1983). Bull (1983, p.31-33). states that ‘[i]n anger, the eyebrows are lowered and drawn together, and vertical lines may appear between eyebrows. Both eyelids are tense; the upper eyelids may be lowered by the actions of the eyebrows while the lower lids may be raised’. In addition, the counsellor’s action also seems to show strong negation; her eyes were nearly closed. Her nose is very wrinkled and her mouth was turned

¹⁰⁰ Ayto (2003) refers to many slang words used for multiple sex such as daisy chain, gang-shag and gang-bang.

down (see Sutton-Spence and Woll, 1999, p.73). At the end of the sequence, the counsellor shows her worries about what she was told by shaking her head and producing ‘°whose sons (.) have not known°’ in a quieter tone as shown in lines 68-69. This action clearly shows that the counsellor is sensitive to what she has been made aware of in prior turns. The following sequences show the counsellor takes an educative role in teaching her patient about the spread of infection.

7.37 [43 – 22:38] [VIDEO]

- | | | | |
|-----|----------|---|--------------------------------------|
| 1. | Nurse: | → | no (.) (you) can help this can't |
| 2. | | → | you? (.) did not help at all (.) |
| 3. | | → | it depends on you (.) you came to |
| 4. | | → | tell me (.) it was ((slightly |
| 5. | | → | shaking head)) useless (.) it is |
| 6. | | → | then not useful (.) to society at |
| 7. | | → | all ((shaking head)) if you do not |
| 8. | | → | stop it |
| 9. | Patient: | | ((nodding)) that why ((stretching |
| 10. | | | two hands)) I do not want |
| 11. | | | to go out if I go out (.) it means |
| 12. | | | the trouble <u>every time</u> do you |
| 13. | | | agree? |
| 14. | Nurse: | → | that (0.1) if you did not know |
| 15. | | → | ((looking up)) how to tell them |
| 16. | | → | that you have got AIDS (0.2) °ask |
| 17. | | → | yourself whether it is right or |
| 18. | | → | not° |
| 19. | Patient: | | ((looking down)) |
| 20. | Nurse: | | right (.) if ((raising two |
| 21. | | | hands up)) this story is true |
| 22. | | | ((putting hands down)) you have to |
| 23. | | | think about its consequences |
| 24. | Patient: | | ((moving mouth)) |

At 22:38 minutes, the excerpt shows the patient has not been behaving himself for the sake of social responsibility as shown in lines 1-8, and an exploration of the patient's knowledge ensues. The term 'knowledge' in this context is different from that in other cases; it does not mean knowledge of prevention. In this case, the counsellor may not need to explore whether this patient knows about safe sex or condom use because this patient is professional. In addition, he talked to the counsellor several times and he was told each time to behave well. He knows well about matters of safe sex and condom use because they have already been discussed profoundly in prior sessions. The term 'knowledge' in this case refers to how far the patient realises his social responsibility and how deliberately he intended to spread the infection. In this area, the way in which the counsellor

explores her patient's knowledge is to use a technique of self-determination. The counsellor expects to know her patient's feelings regarding the infection and how he rationalises it. Thus she told the patient to ask himself whether it is right or not that the patient spread his infection and did not tell others (lines 14-18). At the end of the sequences the counsellor reminds her patient to consider the consequences of spreading infection. The following sequences show the patient hides his infection while he needs other people to acknowledge him. The next sequences show the use of paradox.

7.38 [43 – 27:51] [VIDEO]

- | | | |
|-----|----------|--|
| 1. | Patient: | err: but I have had already |
| 2. | | ((showing a fist)) first I may |
| 3. | | have more strict criteria (.) than |
| 4. | | other people ((counting)) first |
| 5. | | (0.1) have to reveal towards |
| 6. | | society (0.1) second (0.2) every |
| 7. | | friend has to know |
| 8. | Nurse: | ((tossing head)) |
| 9. | Patient: | third (.) parents have to |
| 10. | | acknowledge ((smiling)) |
| 11. | | (0.2) |
| 12. | Nurse: | → ((stretching hands)) uh:: but you |
| 13. | | → forgot to ((showing V-sign)) |
| 14. | | → consider yourself (.) you have got |
| 15. | | → AIDS ((touching chest)) (.) you |
| 16. | | → have ((shaking head)) never |
| 17. | | → revealed to society at all |
| 18. | Patient: | ((smiling)) ((nodding)) |
| 19. | Nurse: | is it [↑right? |
| 20. | Patient: | [(((---nodding 4 times---)) ¹⁰¹ |
| 21. | | correct ((smiling)) |
| 22. | Nurse: | → <u>UH</u> (0.1) then why ((stretching |
| 23. | | → hand)) you have to say that a |
| 24. | | → person staying with you has to |
| 25. | | → reveal [towards society |
| 26. | Patient: | [(((touching forehead)) |

At 27:51 minutes, the patient uses a paradox in his turn when he mentions the revelation of his infection. While he needed other people to acknowledge him, and to reveal their own sexual health, he still keeps his infection confidential, especially when he has sexual intercourse with others. This account was picked up on by the counsellor to continue the interaction. The counsellor asks whether it was reasonable, if the patient needs revelation from others, that the patient does

¹⁰¹ The patient nods continuously 4 times.

not reveal his own situation regarding infection in lines 12-17, and 22-25. The use of this paradox helps move the discussion forward regarding the rationality of confidentiality. The counsellor was also told about another important aspect of sex and taboo in the next sequences.

7.39 [43 – 38:05] [VIDEO]

- | | | |
|-----|----------|--------------------------------------|
| 1. | Patient: | do you know why? just walked |
| 2. | | passing by the monastery |
| 3. | Nurse: | ((tossing)) |
| 4. | Patient: | the novice was teasing (.) Is it |
| 5. | | used to happen? the novice said |
| 6. | | (.) kidding |
| 7. | Nurse: | ((wiping palm of hand)) he was |
| 8. | | just teasing (.) just let it be |
| 9. | Patient: | novice said kidding ((putting palm |
| 10. | | → of hand another arm)) there was |
| 11. | | → once ((moving flat palm of hand)) |
| 12. | | → but used a condom (.) prevented |
| 13. | Nurse: | () |
| 14. | Patient: | ((retracting hand)) novice of |
| 15. | | which monastery ((waving flat palm |
| 16. | | of hand)) I am not telling |
| 17. | | ((laughing)) friend of mine and I |
| 18. | | were riding motorcycle (.) said |
| 19. | | young boys last night (.) had |
| 20. | | visited all over province |
| 21. | | ((laughing)) ((putting head down)) |
| 22. | | all over province (.) the novice |
| 23. | | (0.2) had anything with the monk |
| 24. | | (.) was it sinful? |
| 25. | Nurse: | → ask yourself whether it was sinful |
| 26. | | → or not |

At 38:05 minutes, this patient revealed that he had had sexual relations with a religious novice in one monastery in lines 10-12. As the data show, the counsellor uses the technique of self-determination to answer the patient's question. The counsellor stated that the patient has to ask himself whether what he had done was sinful, in lines 25-26 stating 'ask yourself whether it was sinful or not'. In this case, it is clear that the counsellor does everything for the sake of social order and social responsibility. The counsellor makes a hard attempt to make her patient concerned about social responsibility. The counsellor tried to make her patient adopt every message she gave as much as possible. In this case, the way in which social order was achieved can be seen through the turn-taking. The counsellor has made an attempt to put her patient in order by getting him to

refrain from spreading the infection. In addition, the two different world views of the participants can be seen in this case. While the counsellor would like to stop any spread of infection caused by patients, owing to her theoretical knowledge from training and her moral common sense, the patient has his own account to make his action acceptable to himself. The next sequences show the counsellor's worries about the spread of infection. In addition, the data also show another important aspect in HIV counselling related to the self-evaluation of a counsellor.

7.40 [43 – 43:33] [VIDEO]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | → | because you ((shaking head)) did |
| 2. | | → | not stop spoiling your mind |
| 3. | Patient: | | ((nodding)) |
| 4. | Nurse: | → | I am worried (.) about what you |
| 5. | | → | told me I am worried because (.) |
| 6. | | → | when I think of those ten young |
| 7. | | → | boys' families |
| 8. | Patient: | | ((looking down)) |
| 9. | Nurse: | → | partially (0.2) I take it a |
| 10. | | → | failure (.) in talking with you |
| 11. | | | ((nodding)) really (.) failure |
| 12. | | | because (0.2) err:: the thing (.) |
| 13. | | | you had done (.) for counselling |
| 14. | | | one has to follow our guides which |
| 15. | | | we told (.) advised |
| 16. | Patient: | | ((putting two arms together on the |
| 17. | | | table)) ((looking down)) |
| 18. | Nurse: | | ((moving hands)) to make that |
| 19. | | | person realise (.) change one's |
| 20. | | | behaviour ((moving palms facing |
| 21. | | | flat hands together)) |
| 22. | Patient: | | ((turning face)) |
| 23. | Nurse: | → | but now ((dropping hands)) I |
| 24. | | → | cannot make ((---tapping the |
| 25. | | → | patient's arm 5 times---)) you |
| 26. | | → | change [behaviour |
| 27. | Patient: | | [it is not |
| 28. | Nurse: | | I fail |
| 29. | Patient: | | it is not called a failure |

At 43:33 minutes, the data seem to show that the counsellor worries because she was made aware of the patient's sexual behaviour and his lack of a sense of social responsibility, indicating that he had ignored her advice. In lines 1-2, the counsellor blames the patient for spoiling himself for sexual pleasure. That action led the counsellor to become stressed, especially when the counsellor considers what could happen in the future for the families of those ten young victims in lines 4-7. The data show that the counsellor was not happy with her counselling

task due to her patient's ignorance. The counsellor assesses that she has failed in her job in lines 9-10; she could not make her patient change his behaviour (lines 23-26).

The data exhibit an aspect of counselling evaluation, which is normally evaluated by survey research. Here, I should discuss further the issue of self-evaluation. There is much literature showing how HIV counselling has been evaluated, most of which has been conducted by means of a survey study. The counsellors, as counsellors, were interviewed in-depth, to encourage them to describe their feelings about their tasks. Patients were also interviewed in-depth in order to obtain their views on how satisfactory they find counselling services. The evaluation process is typically investigated separately amongst the clients and lay persons. Although the purpose of this research is not to evaluate the counselling tasks of the counsellors, inevitably there is some empirical evidence emerging from the sessions such that an evaluation could be conducted. In this case, in the excerpt, the counsellor considers her counselling task to have failed.

This case is abnormal and different from the other cases because the counsellor initiates the giving of advice many times. The counsellor intermingles love, morality, forgiveness, social responsibility and the spread of infection. At the end of the conversation, the counsellor exits the context of sexuality by giving advice. The following sequences show that the counsellor should not be assumed to have failed in her job. In addition, the sequences show the counsellor uses an emphatic form to advise her patient about his next sexual intercourse.

7.41 [43 – 53:25] [VIDEO]

- | | | | |
|-----|----------|---|---|
| 1. | Nurse: | | but ((touching the patient's |
| 2. | | | hand)) all (you) told me ((tapping |
| 3. | | | the patient's hand)) thank you |
| 4. | | | very much |
| 5. | Patient: | | ((nodding)) |
| 6. | Nurse: | → | that you told me that I could make |
| 7. | | → | ((clasping hand)) those hundred |
| 8. | | → | people uninfected |
| 9. | Patient: | | yes ((smiling)) [that's right |
| 10. | Nurse: | | [safe |
| 11. | Patient: | | that amount ((moving hand)) |
| 12. | Nurse: | → | <u>BUT</u> ((stretching hand)) from now |
| 13. | | → | on (0.1) if will have (.) please |
| 14. | | → | have it |
| 15. | Patient: | | ((nodding)) |
| 16. | Nurse: | → | with anybody ((clasping hand)) |
| 17. | | → | experienced |

18. Patient: with ((nodding)) me?
19. Nurse: → whether with you or ((stretching
20. → hand)) he has experience with
21. → others (0.1) by ((clasping
22. → hand)) using a condom
23. Patient: ((---nodding 3 times---))¹⁰²
24. Nurse: → ((tapping the patient's hand)) but
25. → with young boys (1.0) let them (.)
26. → ((counting))¹⁰³you have not made
27. → merit for them only (.) you also
28. → make merit (0.1) for their
29. → families (.) for their parents
30. Patient: ((nodding)) ((nodding))
31. ((nodding)) sometimes I think
32. → ((clasping hand)) [that-
33. Nurse: [((slightly
34. stretching body)) you think that
35. → ((touching a patient's hand)) let
36. → me say a word ((touching the
37. → patient's hand)) if you think that
38. → you do not have parents
39. Patient: ((nodding))
40. Nurse: → it is your inferiority
41. Patient: ((nodding))
42. Nurse: ((stretching palm of hand)) then
43. you have to ((clasping hand))
44. destroy others' children
45. ((clasping hand)) have to think
46. the other side (.) that any
47. parents always love their children
48. (.) it is not (.) you do not have
49. parents ((tapping a patient's
50. hand)) the man you used to refer
51. to with me (.) you suspected that
52. he may be your farter
53. Patient: ((nodding))
54. Nurse: it's him (.) he is your father

At 53:25 minutes the beginning of the sequences shows that the patient's actions do not constitute a complete failure of the counsellor's task. Some of the counsellor's actions were successful, confirmed by her patient in that he and his sexual partners used condoms sometimes. In lines 6-8, the counsellor repeated what the patient told her in stating 'that you told me that I could make ((clasping hand)) those hundred people uninfected'. In this excerpt the counsellor told her patient to have sexual intercourse with experienced sexual partners in lines 12-14, and 16-17. In addition, the patient must use condoms when he has sexual intercourse with others, regardless of whether those others have experienced in

¹⁰² The patient responds to the nurse's turn by continuously nodding three times.

¹⁰³ The way in which the nurse counts is by showing all fingers except thumb extended and spread.

lines 19-22. The patient was also told to care about other people’s families in lines 24-29. The spread of infection can be regarded as destructive to those families. One phenomenon illustrated in this case is the use of cut off. The patient makes an attempt to show his own account for spreading infection. The counsellor tries to restrain her patient from providing that account by cutting him off (line 32). In lines 35-36, the counsellor continued the interaction and stated that the patient must let her have her say first. This counsellor’s intense action can illustrate the asymmetrical interaction in that the turn allocation in conversation is not consistent.

The data show that the spread of infection by this male patient is closely related to his vindictive thoughts arising from his status as an orphan. He came from a broken family where the father left prematurely as shown at the end of the sequences in lines 37-38, and 40. The context of sexuality at this stage is exited temporarily by reference to his family. However, the context of sexuality is then reformulated again for discussion. The counsellor and the patient reformulate it when they discuss health and morality. In the last exit of the context of sexuality, the counsellor takes an educative role in teaching her patient about the spread of infection, social responsibility, the destruction of other people’s lives, actions worthy of merit and common sense associated with being Buddhist.

7.42 [43 – 01:02:44] [VIDEO]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Patient: | | [uh:: |
| 2. | Nurse: | → | [prolong life (.) we are happier |
| 3. | | → | (.) especially before we go to bed |
| 4. | | → | and think ((looking up)) what we |
| 5. | | → | did for merit in day time (.) well |
| 6. | | | if we ((showing an index finger)) |
| 7. | | | refrain from spreading infection |
| 8. | | | to someone (.) we have got |
| 9. | | | tremendous merit ((pointing)) |
| 10. | | | that will make us happy ((moving |
| 11. | | | hand around)) liquid of happiness |
| 12. | | | will come out |
| 13. | Patient: | | ((nodding)) |
| 14. | Nurse: | → | ((putting hand down)) virus will |
| 15. | | → | be decreased ¹⁰⁴ |

¹⁰⁴As shown on video, and also as told by two counsellors on an overseas call, the patient worried about his health. Although this is not discussed in this chapter, I should show what really happened to this patient. On video, at 13:23 minutes, a clear illustration is shown of the use of non-verbal communication in health care. The patient told the nurse that he had a fatty tumour, which was not able to be operated on at the provincial hospital. This is because this tumour was located in an important organ of the body. The nurse considers this and uses supportive gestures

16. Patient: ((nodding))

At 01:02:04 minutes, the counsellor educated her patient that he should think about whether any of his actions were worthy of merit each day before going to bed (lines 2-5). He would feel happier if he did so. In addition, to stop spreading infection would be a tremendously meritorious action. When the patient became happy, the liquid of happiness would be produced and released. That would result in decreasing a good deal of the virus in the patient's body, in lines 14-15.

In summary the counsellor was concerned about the spread of infection. She discussed it with this patient in lengthy sequences. She restrained him from spreading infection by applying Buddhist belief.

7.7 Conclusion

My data showed that three aspects of sexual talk were covered in counselling sessions: the first is the managing of public health information-safe sex, the use of condoms and the spread of infection; the second is instructing and advising on sexual practices; the third is sex and well-being. The topic of sexuality is mostly initiated by nurses, and only few times by patients. The nurse and the patient have taken turns to address this sensitive topic. These participants are aware of the sensitivity of this topic, as illustrated through the use of language and body movements. Four different types of question have been applied by nurses during talk-in-interaction. They are general questions, specific questions, allusive questions and hypothetical questions. Each question has its own particular

in her checking process. The way in which the patient shows his cooperation and involvement with medical care is by stretching his neck. The nurse uses gestures in checking the patient's tumour. The way in which the nurse presses the fatty tumour on the patient's neck is to check something important. She presses it by using two important fingers-forefinger and middle fingers. She presses it twice at different areas; both times she presses firmly. The first press correlates with the turn, in which she states that the fatty tumour is located at an important vein. In the next sequences, the nurse told the patient that if this fatty tumour stays still and it does not appear to grow, the patient does not need to worry. The nurse forcefully coaches the patient not to touch or press it. This is because it may become worse in the future. It is imperative to note that this fatty tumour causes the patient's cancer and he eventually passed away soon after I left the research site. Importantly, counsellors acknowledged that he became worse because he had not practised safe sex, and his sexual behaviour increased other viruses in his body, which resulted in other opportunistic infections.

characteristic to be applied with different patients and in different features of conversation. The pathway of talking about sexuality includes: the entry to the topic of sexuality, the matter of giving advice, exploration of the patient's knowledge, and the exit from the context of sexual talk.

The next chapter illustrates the theme of the prospect of death. I show the areas relevant to death which are covered in the main findings. The chapter explores who initiates the topic of death and how the topic is introduced. I show the stages of talking about death, dying and suicide in Thai conversation.

Chapter Eight

The Prospect of Death

8.1 Introduction

In the previous chapter I showed that sexuality and death are delicate topics for discussion in counselling sessions. To some extent, initiating the topic may be difficult. Historical research into the topics of death and dying has been preoccupied with individuals' perceptions of illness trajectories (Lutfey and Maynard, 1998, p.321). Much study of death and dying is conducted by means of survey studies: interviewing individuals about their perceptions towards death and dying. Glaser and Strauss (1965 and 1968) identified four types of awareness contexts-closed awareness, suspicion awareness, mutual pretence and open awareness (Howarth and Leaman, 2001, p. 162). Kübler-Ross (1969) explains the psychological stages people have to experience when they confront death, notably denial, isolation, anger, bargaining, depression and acceptance. These studies are based on ethnographic study.

In the Thai context, Thanaprasertgorn and Nilchaikovit (1997a and 1997b) conducted two surveys titled 'Thai Patients' Perspective about Truth Telling' and 'Thai Physicians' Attitudes towards Truth Telling'. They developed guidelines and questionnaires for cancer patients, non-cancer patients and doctors. In the first piece of work, patients were interviewed using structured questionnaires. The data showed that gender, age, education and the diagnosis of cancer influence the patient's knowledge of illness and attitude toward disclosure of truth. In the latter piece of work, the purpose of the study was to survey the attitudes of physicians towards the disclosure of the diagnosis and prognosis of serious illness, such as cancer, and the practice of truth-telling. Questionnaires were sent to physicians at hospital. The data showed that gender, the degree of involvement in the treatment of cancer patients, and the specialties of physicians are related to attitudes on truth disclosure.

8.2 Death and dying in the context of social interaction

Although the work of Glaser and Strauss (1968, p. 253) utilises ethnographic study, they remark on the importance of interaction in the context of death and dying studies by stating:

'Medical students, for instance, learn not to kill patients through error, and to save patients' lives through diagnosis and treatment; but their teachers have put little or no emphasis on how to talk with dying patients, how (or whether) to disclose an impending death, or even how to approach the subject with wives, children and parents of dying patients' (Glaser and Strauss, 1968, p.253).

This indicates that talk as social interaction is significant and it enables medical students to better understand the issues surrounding death and dying.

Interestingly, Longhofer (1980) suggests that we can understand dying, as a social process in the context of social interaction. This seems to be different from that described by Kübler-Ross (1969). She described dying as internal and inherently progressive stages (see Lutfey and Maynard, 1998).

This chapter illustrates many different features that previous research on death and dying has explored. My study does not focus on the process of death and dying. It sees that talking about death and dying is treated as a difficult subject, consequently I underline how the topic gets started and discussed in interaction in a similar way to Bor and Miller's (1988) study of social interaction in counselling. Peräkylä (1995) conducts research on AIDS counselling. Peräkylä showed that dreaded issues in counselling are addressed in interactional environments between professionals and clients. Lutfey and Maynard (1998) examine the way in which a physician can convey to a patient, and how a patient receives news of an incurable disease like cancer. The studies conducted by Bor, Miller and Peräkylä differ from the work of Lutfey and Maynard, where patients are visibly engaged to initiate talk on death and dying in counselling. In Lutfey and Maynard's work, physicians solicit specific kinds of talk from their patient and try to inform them about their illness trajectories.

In recording natural interaction, researchers who are not medical staff could not be present during the sensitive discussions on death and dying. By

studying death and dying in this manner, the research may be more natural and valid because such talk between medical staff and patients evolves continuously, based on the real relationship between the patient's own sensitivity and needs regarding living and death, and the core tasks of the professionals. My study also takes the view that directly interviewing patients for research might result in the loss of some essential aspect of knowledge about attitudes on death and dying. Patients might not answer all questions or provide all information to researchers, whereas they may be more likely to do so with a counsellor. Peräkylä and Bor (1990, p. 326) point out that '[t]alking about fears of death, dying, illness and its consequences, however, is not an easy task to accomplish'. The counsellors and the clients have to engage in particular ways of talking in order to be able to deal with them.

The way in which I focus on the prospect of death in this chapter is to show the overall main findings from the counselling sessions. The first finding I show is three aspects of death. Then I discuss the topic initiator. Last, I show the stages of talking about death and I also describe the way it is co-constructed by nurses and patients. In discussions of this subject, the particular techniques employed by nurses and patients are described. Individual case studies are used to demonstrate the tactics used to address death in each stage.

8.3 Three aspects of death

Counsellors and care givers were given information on how to deal with patients, and were trained to talk with patients. While the patient is really ill, care givers normally talk to relatives instead. It may be difficult to discuss issues with patients themselves during periods of acute illness. Peräkylä (1993, p. 292)¹¹¹ illustrated how generating talk about illness and death is an essential part of the work of AIDS counsellors. This work has been conducted when the patient is not very ill. My data also show that nurses talked with the patients about the prospect of death when the patient is not acutely ill. The data show that the issue of death described in sessions can be considered in relation to three important facets.

¹¹¹ The ethnographic data also show that most nurses addressed the issue of death when the patients are not at the stage of dying.

The first is the death of patients themselves caused directly by AIDS. This kind of death is closely associated with uncertainty and dying, to which some patients pay great concern. Having been infected with HIV, most patients have anxieties, fears and worries about death and dying because a diagnosis of seropositivity for the HIV virus has been considered to be a death sentence (Roth and Nelson, 1997 and Cherry and Smith, 1993). Barnett and Whiteside (2002, p. 3) state that '[i]t cause illness and death among mature adults'. Kübler-Ross (1987, p.19) remarks this by stating:

'When an AIDS patient called we could not allow a patient to wait that long; we had no guarantee that a patient would still be alive in a year' (Kübler-Ross, 1987, p.19).

These statements represent common views of HIV/AIDS in relation to death. Concerns amongst patients about AIDS-related death can be divided into three aspects.

First, some patients fear the process of dying. They fear disfigurement, purple spots, marks, Kaposi's sarcoma and suchlike on their skin. They are afraid of having a bad image when they become thin and dark.

Second, when patients have children, they worry over the consequences of their own premature death. They worry in terms of who will look after their children. Some patients worry about the children's living arrangements and education. In this area, during one consultation, the nurse makes an attempt to help her patient find a resolution. The nurse has tried to find out if there are cousins or relatives who could help if the need arose. In addition, the nurse also finds out about scholarships and co-operation from schools.

Third, some patients are encouraged to live longer. In this regard, the use of ARVs is referred to. In addition, patients are encouraged to fight against death through the values of self-esteem and worthiness in contributing to society.

The second facet is the death of a third person: one who is close to the patient. These are typically the children, parents, wives and husbands of patients. The death of these third persons is an important issue to be addressed because it is effective in the future planning of patients. Some patients who revealed that their children are also infected are concerned about what will happen to their children after they die. Patients fear stigmatisation and discrimination against

their children, and such discrimination impacts on their children's lives. Thus, in respect of future planning, in the case where the patient's children are also infected with HIV, counsellors must assess who will die first: the patient or his or her child. Frequently, parents, husbands or wives of patients are expected to look after the patients, and indeed, they do so in many regions where AIDS is critical. Thus, in a sense, counsellors allude to what would happen next if those people die first.

Third, the final facet is not death itself, but the consequences of infection with HIV in terms of suicidal thoughts and attempts at suicide. Cote, Biggar and Dannenberg (1992) found an increased risk of suicide in men living with AIDS. The rate of suicide in HIV patients might be as much as 7.4 times that of patients in the general population. WHO (1994b, p.11) states that '[p]eople who learn that they are HIV-infected have a significantly increased risk of suicide'. Although this rate is decreasing with time, the issue of suicide still remains a major concern of medical staff dealing with HIV/AIDS. Suicide amongst HIV patients remains a major issue in mental psychotherapy. O'Dowd and Zofnass (1991, p. 203) also demonstrate an association between HIV/AIDS, depression¹¹², and suicide. The diagnosis of AIDS may lead some patients to a risk of suicide. Nilchaikovit (1994), a senior Thai psychiatrist, has discussed the prospect of AIDS-related suicide in psychotherapy. He suggests that counsellors should continuously assess HIV/AIDS patients in case they develop suicidal thoughts or attempt to take their own lives at any stage of adjusting themselves to their condition, especially if they begin to feel desperate.

Therefore it is important for nurses, in their role as counsellors, always to make an attempt to assess whether their patients may be suicidal. Despite the fact that patients have been prepared well with either pre-test counselling or post-test counselling, suicide remains a clear option for some patients in the wake of discovering their infection. In addition, although there is a treatment in the form of ARVs, some patients might prefer to kill themselves in order to avoid stigma, denial and other problems associated with HIV/AIDS. This study illustrates three main reasons why counsellors should address suicide attempts by some patients.

¹¹² The suicide in AIDS may be regarded as melancholy suicide. Durkheim (1952,) states that melancholy suicide is related to depression and sadness. This may cause the patient realises that he or she no longer connects with people and things around them.

The first is in relation to the fact most counsellors are Buddhist. Thus, they have also been oriented in the teaching of the lord Buddha regarding life after death. In the teaching of the lord Buddha, all Buddhists are told to follow the five principal precepts or the five rules of morality. The first precept amongst all is that 'I undertake to observe the precept to abstain from taking life' (Phra Dhammapidok, 2000, p. 206). Thai people are brought up to have compassion and not to take another person's life. In addition, they believe that all other lives are valuable, and so of course, counsellors take the value of anyone's life seriously. It is important that counsellors try to prevent their patients from committing suicide. In addition, as most Thai people are Buddhist, they are brought up to believe in life after death. The term 'life after death' is connected to the manner of death in terms of whether it is through natural or unnatural causes. Natural causes of death are those according to life expectancy (i.e. being old) and death from sickness. In Thai society, suicide is considered as 'unnatural death' or 'abnormal death'. This pattern of death is called in Thai '*Tai Hoeng*'. *Tai Hoeng* is the word used rarely to describe tragic manners of death, which are considered abnormal. Examples of abnormal death are death from childbirth, accidents, homicide and suicide. In this area, Tambiah (1970, p.179) remarks on the pattern of death in North-east Thailand, which can be generalised to all parts of Thailand. Tambiah (ibid) states that the manner or '[t]he form of death is believed to have vital significance for the fate of the soul (*winjan*), and special precautions are taken in the case of sudden death'. In others words, if one has had an abnormal death or successful suicide, he or she would be considered sinful. One's fate after death is defined in terms of karma or action. In addition, counsellors should have *Brahmavihara* 4—four noble sentiments or holy abidings. These consist of *metta*—loving-kindness, *karuna*—compassion, *mudita*—sympathetic joy and *upekkha*—neutrality. Wongrakmitte (2003) states that holding metta encourages counsellors to wish their patients out of a state of suffering. At this point, we must refrain from killing or taking away one's life, including our own life. The belief associated with the manner of death is that most Thai people require a natural death. The nurse may find it necessary to spontaneously allude to the suicidal attempt of any patient.

The second aspect of counsellors addressing suicide arose in two training courses I participated in during the six months of field work: training courses

emphasized the need to address the issue of suicide in counselling. In addition, the counsellors have an obligation to ensure that patients are dissuaded from making any suicide attempts. Nilchaikovit (1993a), who became involved with HIV counselling at the start of the epidemic, remarks that in some cases living with HIV/AIDS can make patients worry and then consider suicide. One purpose of counselling with HIV/AIDS patients is to assess how they consider suicide. They might need referral to psychiatrists if it appears that they have suicidal intent. Patients who have been touched by suicide will be in need of counselling. Counsellors should allude to suicidal attempts by patients if there are clear clues as to those attempts (see Miller and Bor, 1991, p. 56).

The third and final aspect of suicide in counselling is that it might result in difficulties and hardships for others, such as the children or parents of patients. If patients are successful in committing suicide, they might leave burdens for their family members. The death of a patient in this manner does not mean just death in the biomedical dimension—the stopping of breath or the bodily system. It is much more meaningful in the sense that the dead patient is no longer available for social interaction, and some questions might be posed by others outside the family, such as ‘what makes him or her end his or her life like that’. Henley (1983, p. 6) found from his research that death by suicide results in a bereavement more devastating than any other forms of death.

While some counsellors have made an attempt to allude to whether their patients consider suicide as a way to end their life, those patients are typically not those with full-blown AIDS. Thus patients are not motivated to commit suicide to get rid of physical pain or suffering. The cause of suicide is the question to which the counsellors have to find their own answers in each session. One of the major concerns in HIV counselling is how nurses as counsellors can facilitate discussion with patients about uncertainty and death and assess their patients’ views regarding suicide. Peräkylä (1995, p. 232) demonstrates that ‘counsellors want to encourage their clients to talk about issues like illness, deterioration, pain, separation and death well in advance of their possible occurrence in the patients’ lives’. In the context of HIV/AIDS counselling, issues of dread should be addressed because the existence of dreaded issues around HIV/AIDS is undeniable. However, managing to talk with patients regarding these concerns might be an intricate problem for counsellors. Bor and Miller (1988, p.399) state

that 'if we could find a suitable way of discussing these 'dread issues', then we might help other staff in the management of patients which may relieve some of the pressure on them'. Here, I highlight how talking about issues of dread can result in benefits for both counsellors and patients. I have shown the aspects of death covered in counselling sessions. In the next section, I illustrate who initiates the topic of death.

8.4 Topic initiator

In my data, when the topic of death is focused on, it is most frequently introduced or initiated by nurses. Patients rarely initiated the topic. The topic of death initiated by a patient appears in a direct manner. Four patients deliberately initiated the topic, which was then continued by the nurses for further discussion.¹¹³ In one case, the patient initiates the topic by referring to his father's death. Then he brought his concern about his own death into the discussion because he was concerned with dying, in connection to things such as the stage of his infection, bad image and disfigurements in the future.¹¹⁴ Two female patients worried about the premature death of their children.¹¹⁵ Another female patient wished to pass away as soon as possible to avoid any trouble in life.¹¹⁶ There is no discussion on death and dying in some sessions.¹¹⁷ The way in which counsellors address the delicate topic can be divided into three characteristics.

First, in most cases, death is referred to in general rather than specific ways. Counsellors might talk about or explain the stages of infection in sequence. In explaining the stages and symptoms, counsellors have to refer to the critical

¹¹³ The patients in case no. 04, 09, 23 and 36 initiated the topic.

¹¹⁴ This takes place in case no. 04.

¹¹⁵ Those worries are illustrated in cases no. 09 and 36. Both worried about their children's premature death. In case no. 09, the patient initiated the topic by referring to her daughter's premature death. In case no. 36, she mentioned the first death by referring to the death of a third person, but it was not discussed further. She initiated the topic by introducing the thought of a suicide attempt if her son dies before her. This was discussed further.

¹¹⁶ This is a wish of the female patient in case no.23.

¹¹⁷ There is no discussion on death in some cases; for example in case no.05. The patient of this case was in an acute condition. But two counsellors did not address the dread issue with the patient or relatives. This is relevant to the statement of Peräkylä (1993, p. 292) in that the dread issue will be brought into discussion when the patient is not dying. I was told by the counsellors that this patient passed away after I left the research site.

stage which involves death. Death referred to in this stage can be considered as impersonal.

Second, counsellors initiate the topic of death by referring to the death of a third person. In counselling cases, the death of a third party might mean death amongst patients' friends, parents and husbands or wives. It is possible that referring to death in such a manner prepares patients for more discussion of death in following sequences of health talk.

Third, the nurse initiated the topic by picking up the death of a third person mentioned by the patient. In mentioning death, the patient provides an opportunity for counsellors to follow up with the connection between the death of the third person and the patient's own death. However, counsellors do not always take this opportunity to probe further about the death of their patient. This study found that in some cases, counsellors began alluding to the topic in much later sequences of talk.

Here I illustrate some examples in which the topics are initiated by both patient and nurse.

8.1 [04 – 04:02] [VIDEO]

[The counsellor was a midwife. This patient was a male homosexual. He used to be involved with commercial sex work in Bangkok. He was not on the ARV programme. He helped his sister run a business. To some extent, his infection affects his business.]

- | | | |
|-----|----------|------------------------------------|
| 1. | Patient: | He knew ((touching breast)) that |
| 2. | | I [got virus ((touching eye)) |
| 3. | Nurse: | [orr:: ((shaking head)) but he |
| 4. | | did not know (you) get [infected |
| 5. | Patient: | [at home |
| 6. | | (.) nobody tells |
| 7. | Nurse: | right ((nodding)) |
| 8. | Patient: | right |
| 9. | Nurse: | °think that (.) got normal |
| 10. | | [virus° ((clicking a pen)) |
| 11. | Patient: | [that (.) do not want him to know |
| 12. | | because if (0.2) he knows he might |
| 13. | | be (0.2) [upset |
| 14. | Nurse: | [first ((counting)) |
| 15. | | upset |
| 16. | Patient: | or (.) probably [go- |
| 17. | Nurse: | [second can not |
| 18. | | ((nodding)) [right |
| 19. | Patient: | [can not accept (.) |
| 20. | | might go before us |
| 21. | Nurse: | ((nodding)) ((nodding)) |
| 22. | Patient: | because previously |

23. Nurse: ((holding a pen))
 24. Patient: he blamed °one's child in this
 25. house got AIDS (.) one in that
 26. house got° [AIDS
 27. Nurse: ((clicking a pen))
 28. Patient: [this time ((pointing breast))
 29. Nurse: [orr::he antis¹¹⁸

At 04:02 minutes, the counsellor and the patient talk about the patient's infection before. The patient initiates the topic regarding death by stating that his father might pass away before him if his father knows about his infection.

8.2 [04 – 11:54] [VIDEO]

1. Patient: but sometimes, I think that uh
 2. Nurse: ((moving backwards)) ((relaxing))
 3. Patient: → if go a bit earlier °than this°
 4. → should be good ((nodding))
 5. Nurse: UH
 6. Patient: → that pass away
 7. Nurse: ↑why?
 8. Patient: → because do not want to see my body
 9. → (.) skinny
 10. Nurse: ((moving head))
 11. Patient: → that image becomes like that
 12. Nurse: ((smiling))
 13. Patient: → ((laughing)) .hhh ((raising
 14. → shoulders)) pii (the counsellor's
 15. → name) I fear

In example # 8.2, the patient's turn at line 3 shows how he aims to develop the topic of death. He does not use any utterance explicitly referring to death, but instead uses another utterance which can be interpreted in this context as being in relation to death. It is 'if go a bit earlier °than this° should be good ((nodding))' as shown in lines 3-4. This kind of tactic is the use of lexical choice or euphemism. In the patient's next turn, as shown in line 6, the patient does a repair clarifying what he meant as 'that pass away' making his statement sufficiently clear to be interpreted as being in connection to death. The main reason why this patient initiates the topic of death seems not to be that he fears death as such, but that he fears the process of dying. His turns are self-explanatory. He shows his fear of dying as being associated with 'because do not want to see my body (.) skinny' (lines 8-9), 'that image becomes like that' (in line 11), and '((laughing))

¹¹⁸ The nurse pronounced this word in English-anti.

.hhh ((raising shoulders)) pii (the counsellor's name) I fear' in lines 13-15.¹¹⁹

The following example shows how the counsellor who was a health educator, initiates the topic by referring to the death of a third person.

8.3 [25 – 03:11] [VIDEO]

[The counsellor was a health educator. The patient was a male homosexual aged 50. He was on the ARV programme.]

- | | | |
|-----|----------|--|
| 1. | Nurse: | ((counting)) I have known jae ¹²⁰ |
| 2. | | Sri (.) jae Auon |
| 3. | Patient: | Sri (.) Auon (.) both are friends |
| 4. | | (.) same age |
| 5. | Nurse: | → ah:: >jae Sri <u>died</u> already?< |
| 6. | Patient: | → ((nodding)) <u>died</u> ↑already |
| 7. | Nurse: | right |
| 8. | Patient: | jae Sri also died of AIDS |
| 9. | Nurse: | this jae Auon (.) (I) ((nodding)) |
| 10. | | am very close to pii (the |
| 11. | | patient's name) |

At 03:11 minutes, the counsellor addresses it in the form of impersonal death. In line 5, she mentions the name of some patients who had died as a result of AIDS. In line 6, the patient produces utterances to agree with what is mentioned in the prior turn. This kind of action can be considered as an upgrading agreement. At this point, I should elaborate that the counsellor does not mention the names at random. In the prior turns, the patient told the counsellor about his workplace and the friends he used to work with. The counsellor then picked up on those friends' names and probed further. As with other similar counselling cases, the way in which the counsellor raises the topic of death enables her to prepare her patient gradually to talk about death.

In summary, my data showed that the nurse treated talking about death as a difficult task. This is reflected in the way in which the nurse initiated the topic. The delicacy and awkwardness of talking about death and dying does not only apply in interaction itself, but also to managing interaction. The nurse wished to know about the patient's plan for the future and whether suicide has been contemplated. The nurse initiates the topic indirectly whereas the patient

¹¹⁹ The next sequences are concerned with the use of ARVs. The patient showed that he needs to live longer. The counsellor encourages him to use ARVs (see Chapter five on joining and selecting for the programme on antiretrovirals, in example # 5.7).

¹²⁰ The word 'jae' originated from Chinese dialect. It is used to address a female person who is in higher status regardless of age or social respect.

introduces it bluntly. In the next section I show how the topic of death is initiated and discussed in different stages.

8.5 Stages in talking about death

In reviewing the following counselling case, CA clearly reveals a particular format of talking about death and dying. CA helps identify how talking about death is typically conducted in a manner of stages.

8.4 [35 – 07:46] [VIDEO]

[The patient was a monk. He wished to participate in the ARV programme.]

1. Nurse: someone may have lymphosis (.)
2. lymphosis (.) which this ((looking
3. straight)) can be observed easily
4. around ((tapping neck)¹²¹
5. Patient: (uh)
6. Nurse: right neck ((touching neck)¹²²
7. Patient: neck
8. Nurse: for someone (.) there might be
9. ((pointing groin)) at groin
10. ((pointing armpit)) around armpit
11. Patient: ((slightly nodding))
12. Nurse: those might possibly become
13. °cancer of lymph gland°.
14. Patient: ((slight nodding)) uh
15. Nurse: someone may have flatulent
16. stomach (.) possibly liver cancer
17. flatulent stomach or headache (.)
18. chronic headache this headache (.)
19. caused by the virus (.) may go up
20. to the brain right (.) someone
21. becomes ((moving an index
22. finger))¹²³ blind can not see at
23. all
24. Patient: ((nodding))
25. Nurse: numb ((stretching hands)) at
26. fingers (.) toes (.) peripheral
27. neuropathy ((pursing hands)) of
28. hands and feet (.) those are in
29. second stage
30. Patient: ((nodding))
31. Nurse: then it will be the third stage
32. ((looking outside)) this third
33. stage ((looking at the patient))

¹²¹ The nurse taps her neck using an index finger.

¹²² The nurse touches her neck using two index fingers to point either side of her neck.

¹²³ The nurse moves an index finger around quickly.

34. lasts (.) about two years
 35. Patient: ((nodding)) uh (.) two years
 36. Nurse: → in third stage then might have a
 37. → chance to (2.8) °die°¹²⁴((laughing))
 38. Patient: → come [closer
 39. Nurse: [that time ((smiling))
 40. Patient: err::
 41. Nurse: → I do beg your pardon ((wai))¹²⁵
 42. → saying that (.) have to die
 43. ((moving legs)) ((moving
 44. backwards))
 45. Patient: don't worry (.) naturally
 46. (.) when one was born (.) then
 47. dies
 48. Nurse: right (.) right (.) it is possible
 49. (.) although (we) are in the first
 50. stage (.) if we have behaviour at
 51. risk ((stretching fingers of two
 52. hands)) (.) we may have been into
 53. second stage earlier
 54. Patient: ((slightly nodding))
 55. Nurse: if we behave properly
 56. Patient: ((nodding))
 57. Nurse: may have life ((stretching fingers
 58. of right hand)) or into second
 59. stage rather

We have seen that the topic is initiated by the nurse. In this stage, I refer to it as describing the course of infection and disease. The nurse starts talking about death at 07:46 minutes. She introduces this topic by describing the course of infection and the characteristics of the disease. In connection with the early stage of his knowledge concerning his infection, the nurse explains to the patient about what HIV/AIDS is, how it is transmitted, and what its consequences are. The conversation at this stage is mainly concerned with the details of infection and disease. In addition, the nurse first addresses the issue of death in general. The death referred to in this context is the impersonal form of death. She does not directly address the death of the patient. One elaboration for this might be that she is assessing her patient for how far he has grasped the concept of death, in particular, death caused by AIDS. In lines 36-37, she raises the issue of the third stage of infection, in which the patient might encounter death stating 'in third stage then might have a chance to (2.8) °die° ((laughing))'.¹²⁶ This is an

¹²⁴ The word 'die' has a sound like the word meaning death in Thai. In Thai, it is pronounced 'Tai'.

¹²⁵ *Wai* is the action of putting the two palms of the hands together in front of the chest.

¹²⁶ The laughter in this context was discussed during ICCA06. Conference participants agreed that such laughter was used because the nurse was embarrassed.

example of a tactic used by the counsellor to allude to death and dying. The sensitivity of the topic is visible. The nurse produces a pause (2.8) before she mentions the word 'die'. In addition, she pronounces the word 'die' with a quieter tone. As well as this tactic for alluding to death, the nurse also uses non-verbal communication. She uses an action of '*wai*' and the utterance 'I do beg your pardon' in line 41. This sentence is placed at the beginning of the turn produced by the nurse and it is followed by 'saying that (.) have to die' in line 42. She does not do it to correct what the patient said in the prior turn; the purpose of this utterance is an apologetic form but it is not a serious kind of apology. It has been employed to this context so that she can move on from the prior turn, and indicates that what she is about to say is not a good thing. She does not mean to curse her patient. In this respect, I should explain that in Thai society, referring to death with more senior citizens might be considered impolite. Thus before one mentions death with someone who is older, some utterances or an action, such as 'I beg your pardon', 'I am sorry' or '*wai*', must be used. In addition, the mentioning of death with this patient, for nurse seems rather brutal but necessary. The nurse might want to communicate to her patient the fact that she is sorry to tell him that he is likely to die when that stage of infection is reached. I should pose the question of how this is addressed in counselling theory. The nurse knows that the topic of death and dying is sensitive, and consequently she has to use informative tactics to probe towards the death. Although this tactic used seems to be rather forthright speech, it is smooth and efficient. Then both nurse and patient can share mutual sensitivity and directness in talking about death. In line 38, the patient repeats the nurse's prior utterance, 'come closer', which means that death is coming. Here, this can be regarded as response and consolidation of co-participants. The nurse stressed that how slowly the patient's infection develops at each stage of the disease depends on how the patient behaves. The following excerpt illustrates another two stages of talking about death that are refocusing from a general address into a specific address and the exit from the context of death.

8.5 [35 – 19:29] [VIDEO]

- | | | | |
|----|--------|---|---------------------------------|
| 1. | Nurse: | → | ((looking down the desk)) (1.0) |
| 2. | | → | and a plan ((looking at the |

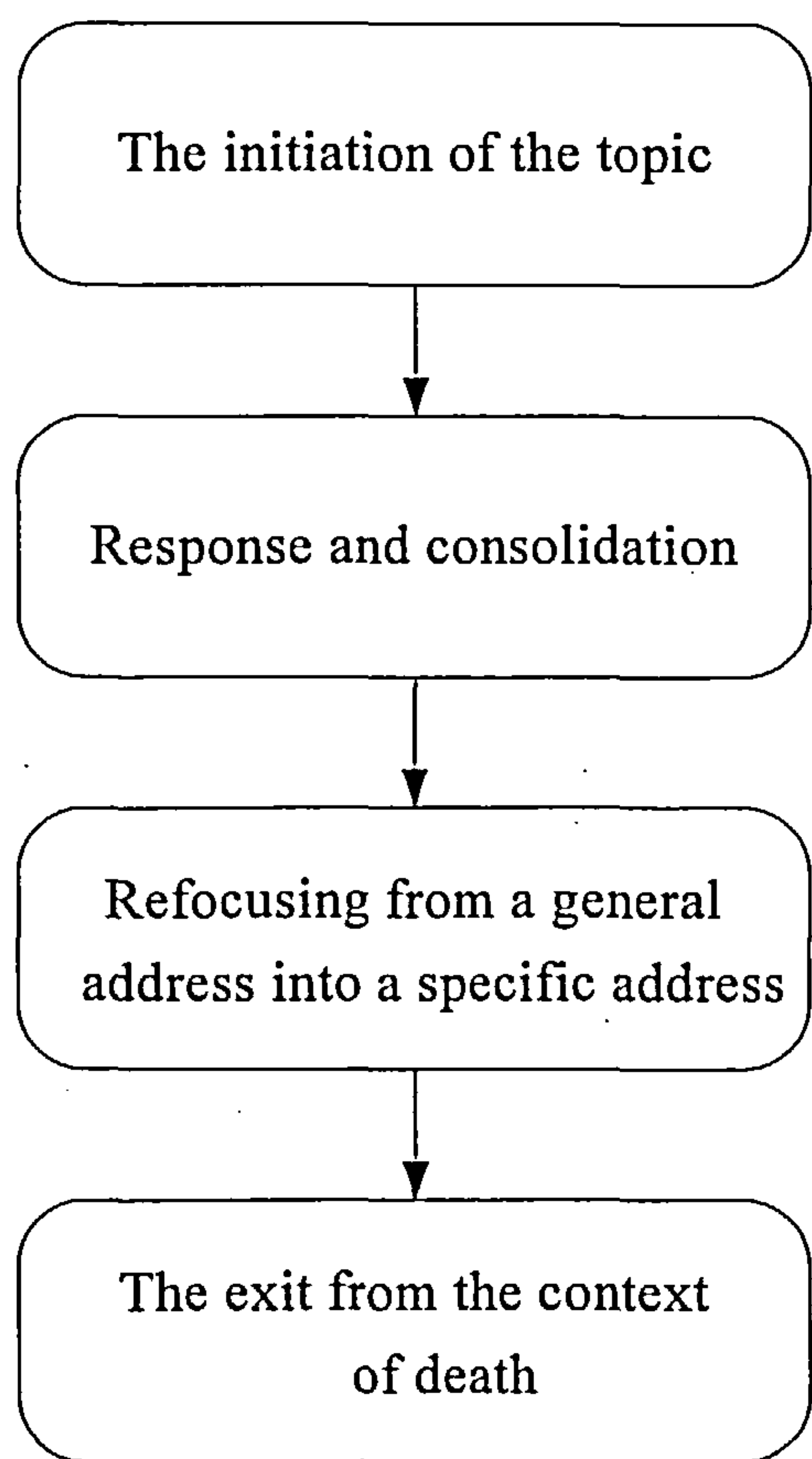
3. → patient's face)) for life
 4. → Than Jao think (3.0) how do you
 5. → plan?
 6. Patient: → this time (1.0) I try to be
 7. → healthy (.) try to do exercise (.)
 8. → walking up and down or doing yoga
 9. → for increasing immune (.) to fight
 10. → against this disease (.) do not
 11. → make body weak (.) or get virus
 12. → from other diseases (.) If I do
 13. → exercises every morning and
 14. → evening (.) do yoga and do
 15. → meditation walk up and down (.) I
 16. → will live longer (.) regarding
 17. → death (.) this death I will
 18. → definitely die (.) sooner or later
 19. → (.) but when karma comes ((moving
 20. → fingers)) the death is coming
 21. → (13.0)
 22. Nurse: → apart from this (.) Jao said that
 23. Patient: .hhh
 24. Nurse: → death (.) cannot be avoided
 25. → ((smiling)) [nobody
 26. Patient: → [nobody can avoid
 27. Nurse: uh nobody can avoid (.) in terms
 28. of dying (.) behaving is the most
 29. important (.) right ((nodding))
 30. Patient: ((nodding)) uh
 31. Nurse: particularly (.) err:: stress (.)
 32. right ((nodding)) stress (.) must
 33. have concentration right?
 34. Patient: ((nodding))
 35. Nurse: have consciousness right?
 36. Patient: ((nodding))

At 19:29 minutes, in lines 1-5, the nurse produces ‘((looking down the desk)) (1.0) and a plan ((looking at the patient's face)) for life Than Jao think (3.0) how do you plan?’ to confirm what the patient thinks about death or preparations for the future and uncertainty. At this stage the nurse refocuses smoothly but critically from a general address into a specific address. In lines 6-20, the patient produces his turn which I refer to as a tactic of fatalistic and fake fashion and naturalization. He uses a particular tactic to attempt to make his death natural. He elaborates to the nurse how he can be healthy and how he can delay death. He claims that meditation, exercise and yoga may be useful. He renders the death natural in terms of Buddhist belief. In line 18, he states that the death will come sooner or later, thus he should accept it. This kind of utterance can naturalize death. This exhibits the way in which he can downgrade death or make death weaker or simpler. In addition, this represents how he has been oriented to

religious belief in his religious institution. His turn shows how his knowledge of death is constructed or shaped through the social structures of monkhood. At the end of his turn he uses the Buddhist aspect to shape his speech, as shown in lines 16-20. He states ‘...regarding death (.) this death I will definitely die (.) sooner or later (.) but when karma comes ((moving fingers)) the death is coming’ His meaning of death is in relation to karma in Buddhist belief. In the next step the nurse would like to exit from the context of death, consequently she uses something which I refer to as acceptance and optimistic exit. The nurse constructs utterances in relation to acceptance by stating ‘apart from this (.) Jao said that’ in line 22, and ‘death (.) cannot be avoided ((smiling)) [nobody]’ in lines 24-25. At this point, there might be a question as to whether she can exit the context of death smoothly. The answer is ‘yes’, and we know this because in the next turn produced by the patient, he confirms and agrees with what the nurse said in the prior turn. The way in which he produces his utterance should be noticed. He uses an overlap in line 26 in stating ‘[nobody can avoid]’. This exhibits the way in which the nurse and the patient talk about death and dying when the patient has to confront it.

In summary, the case demonstrates the stages of talking about death. The stages consist of the initiation of the topic, response and consolidation, refocusing from a general address into a specific address, and the exit from the context of death. In reviewing most counselling sessions where the topic is addressed we can find these stages as illustrated in Diagram 9. Next, I describe each stage in detail, underpinning the description with some examples.

Diagram 9. Stages in talking about death



8.5.1 The initiation of the topic

First is the initiation of the topic of death. In most cases, the topic of death is initiated by the nurse. There are many different ways in which the topic is introduced. The nurse may refer to the general, impersonal death of other people. Apart from such references, the topic might be addressed by describing the course of infection such as the symptoms of HIV/AIDS, including the stages of infection. In addition, in some cases, nurses initiate the topic of death by referring to a third person who is close to the patient. With regard to the topic initiated by patients, most patients start it directly by talking about their own death and that of other persons such as children. Each individual will have his or her own technique to introduce these issues as shown next.

The first example shows the nurse offers the patient an opportunity to state what she wishes to discuss. This kind of question is referred to as a topic elicitation (see Peräkylä,1995, p.241). It is used when a counsellor offers a

patient an opportunity to initiate some issues he or she wants to raise during the session. The data show that the patient initiates the topic of death by referring to the death of her daughter. The patient herself directly initiates the topic of death, but she does not worry considerably about her own death. She is afraid of the premature death of her daughter. Her daughter has been diagnosed with a leaking valve in her heart and narrowed aortic valve heart disease.

8.6 [09 – 03:52 [VIDEO]

[The patient was a widow. She is living with her daughter. Her daughter was not infected, but had been diagnosed with a leaking valve in her heart and narrowed aortic valve heart disease. The patient was on the ARV programme.]

- | | | | |
|----|----------|---|-----------------------------------|
| 1. | Nurse: | → | this (.) what (.) anything (you) |
| 2. | | → | want to tell? (I) would like to |
| 3. | | → | tell (.) that everything you tell |
| 4. | | → | will be kept confidential |
| 5. | Patient: | | ((nodding)) |
| 6. | Nurse: | | if anything (0.2) you want me (.) |
| 7. | | | to help (1.0) I will do you can |
| 8. | | | tell everything (.) which makes |
| 9. | | | you happy |

The counsellor asks about what really concerns her patient and the patient would like to discuss as shown in lines 1-4. In the next turn, the nurse reassures the patient that what is discussed is kept confidential.

8.7 [09 – 04:57] [VIDEO]

- | | | | |
|-----|----------|---|-------------------------------------|
| 1. | Patient: | | now (I) have been stressed |
| 2. | Nurse: | | ((getting face tissues)) |
| 3. | Patient: | → | (I) do not know ((touching nose)) |
| 4. | | → | (I) am afraid ((wobbly voice)) |
| 5. | | → | daughter will <u>DIE</u> ((crying)) |
| 6. | Nurse: | | ((folding face tissues)) |
| 7. | Patient: | | ((looking out)) |
| 8. | Nurse: | | ((giving the patient face |
| 9. | | | tissues)) |
| 10. | Patient: | | ((drying tears with face tissues)) |

After the patient is offered the chance to raise an issue, she brings the premature death of her own daughter into discussion. In initiating the topic, she uses strong emotion by crying when she is aware of dying, and marks the topic out as one of concern. As shown in lines 3-5, she is crying when she states that she is afraid of her daughter's death. The patient stresses the word 'DIE' in line 5.

The following example shows another feature of initiating the topic of death. The topic is initiated by a patient by omitting a word clue. This technique makes what concerns her salient to the counsellor.

8.8 [23 – 28:40] [VIDEO]

[The counsellor was a health educator. The patient was a widow, and a single mother. She was on the ARV programme.]

- | | | |
|-----|----------|--------------------------------------|
| 1. | Nurse: | I think that ((nodding)) every |
| 2. | | problem |
| 3. | Patient: | ((nodding)) |
| 4. | Nurse: | can be solved ((twitching |
| 5. | | fingers)) |
| 6. | Patient: | ((nodding)) |
| 7. | Nurse: | it depends on which way |
| 8. | Patient: | ((nodding)) |
| 9. | Nurse: | they can be sorted out |
| 10. | Patient: | ((sniffing)) sometimes (I) felt |
| 11. | | → bored (.) bored (2.0) would like |
| 12. | | → to ((crying)) (1.0) properly (.) |
| 13. | | → at the end of the day |
| 14. | Nurse: | → that's not good to do so (.) think |
| 15. | | so (.) that would be sinful (.) |
| 16. | | you will leave burdens with your |
| 17. | | son |

At 28:40 minutes, the patient and the counsellor discuss the patient's life, economic situation and family. The patient initiates the topic of suicide by using her own techniques. It appears similar to tasks we used to get involved with in our primary school. I will refer to it as a practice or lesson of 'filling a word in the blank'. Our teachers sometimes told us as pupils to supply a word in the blank space left in a sentence. If we filled in the wrong words, we might not get a good result. Similarly, this practice becomes a tactic used by some patients. The preceding excerpt shows that she omits a word in her turn. In lines 11-12, the patient produces the utterances '...bored (.) bored (2.0) would like to ((crying)) (1.0) properly (.)...' as a clue for death or suicide. The kind of word the counsellor should use to fill in the blank must be considered in the context of counselling. It is not surprising that the counsellor fills the right words in the blank because the counsellor and patient are talking in the same context of death, and they understand each other well. This kind of social action makes their conversation continue smoothly. In line 12, the patient uses a pause (1.0), which means something negative. By contrast, we might think what would happen, if

the counsellor had chosen the wrong word? Both of them might then struggle in continuing to talk about death. In addition, the patient uses the idiomatic form as figure of speech (see Drew and Holt, 1998) to formulate the topic of death. In line 13, the patient designs her turn by stating 'at the end of the day' as another clue allusive to death or suicide. In this area, it is clear that the patient is successful in rendering her topic one of concern because the counsellor knows what kinds of word she should use to fill in the blank. In the counsellor's turn in line 14, she states 'that's not good to do so...'. This indicates that the word which the patient leaves out must be something negative. Thus the counsellor seriously prohibits the patient from thinking about or doing the thing in question.

In the next example, although this health consultation occurs at home, most of the topics addressed are related to health-care. In this case, '[t]hus the institutionality of interaction is not determined by its setting' (Drew and Heritage, 1992, p.3, and see also Drew and Sorjonen, 1997, p. 92). The patient initiates the topic by referring to the thought of suicide. The following excerpt shows that the patient might consider suicide if her son dies before her.

8.9 [36 – 13:58] [VIDEO]

[The counselling was held at the patient's home. The patient was a widow, and single mother. She is living with a son; her son was infected. She had given up taking ARVs, but she has now restarted them.]

- | | | |
|-----|----------|-------------------------------------|
| 1. | Patient: | ((nodding)) right (.) that |
| 2. | | accompanying me until nowadays |
| 3. | Nurse: | uh (.) uh (.) uh |
| 4. | Patient: | be my inspiration |
| 5. | Nurse: | ((scratching forehead)) |
| 6. | Patient: | → I rethought about this if I did |
| 7. | | → not have him >I would have a neck |
| 8. | | → hung a long time ago< I thought |
| 9. | | → like= |
| 10. | Nurse: | → =do not think like that think |
| 11. | | → further that (.) life can be |
| 12. | | → expected |
| 13. | Patient: | .hhh |
| 14. | Nurse: | face hard life right (.) someone |
| 15. | | is poor (.) bankrupt ((moving |
| 16. | | hand)) one can recover ((moving |
| 17. | | hand)) has money right, |
| 18. | Patient: | I only (.) think of my son (0.1) |
| 19. | | until now (0.2) if have not son |
| 20. | | ((shaking head)) I will not be |

At 13:58 minutes, she initiates discussion of her own suicidal thoughts. In lines 6-9 she states that she would rather be hung if it was not for her son. The nurse immediately constructs positive utterances in response in her turn in lines 10-12 stating 'do not think like that think further that (.) life can be expected'. The way in which the nurse restrains the patient from thinking about suicide is by producing utterances continuously after the patient's turn.

In case no.41, the topic of death is initiated by the counsellor who is a midwife. The patient shows considerable worries about having cancer. The counsellor uses a direct question about her worries to classify what she really worries about, whether it is cancer or death.

8.10 [41 – 02:35] [VIDEO]

[The counsellor was a midwife. The patient was a widow, and a single mother. She was on the ARV programme.]

- | | | | |
|-----|----------|---|------------------------------------|
| 1. | Nurse: | → | what do you fear (0.1) just say |
| 2. | Patient: | | afraid of cancer ((smiling)) |
| 3. | Nurse: | | ((smiling)) (0.2) worry until now |
| 4. | Patient: | | ((laughing)) ((raising shoulder |
| 5. | | | up)) ((laughing)) |
| 6. | Nurse: | | ((laughing)) |
| 7. | Patient: | → | ((laughing)) afraid of cancer |
| 8. | | | (2.0) .hhh only |
| 9. | Nurse: | | I will tell (.) how to tell (.) |
| 10. | | | to make happy that (.) we can find |
| 11. | | | it ((nodding)) |
| 12. | Patient: | | can be found ((nodding)) |
| 13. | Nurse: | | amongst HIV patients (.) at one |
| 14. | | | stage (.) there have been |
| 15. | | | symptoms of skin cancer |
| 16. | | | ((nodding)) or lymphoma |
| 17. | | | ((nodding)) |
| 18. | Patient: | | ((nodding)) |
| 19. | Nurse: | | but it is not often found (3.0) |
| 20. | | → | like (1.0) Nongkran's case right |
| 21. | Patient: | | ((slightly tossing head)) |
| 22. | Nurse: | | who lived at Ban Thar Ler (.) died |
| 23. | | | (.) found to be urethral cancer |
| 24. | | → | right (3.0) ((moving forwards to |
| 25. | | → | patient)) ((touching the patient's |
| 26. | | → | leg)) I mentioned this (.) I |
| 27. | | → | don't mean (.) to make you [worry |
| 28. | Patient: | | [uh |
| 29. | | | ((slightly shaking head)) |
| 30. | | | ((smiling)) |
| 31. | | | (0.2) |
| 32. | Nurse: | → | (you) are afraid of cancer (.) |
| 33. | | → | afraid of only cancer or also |
| 34. | | → | fear death |
| 35. | Patient: | | ((slightly shaking head)) do not |

36.	fear death (.) afraid of cancer
37.	because I am afraid of suffering
38.	(.) when got <u>PAIN</u>

At 02:35 minutes, the counsellor would like to know whether it is the fear of cancer, or the fear of death that really concerns the patient, so she uses a direct question in line 1. It seems that she is successful because the patient clarifies to that she fears getting cancer in line 7. At this stage, the counsellor clarifies the patient that cancer is rare, but it is a possibility. At this point one might pose the question of why this kind of direct question is used. There is one possible explanation for this in that, in other prior turns, both the patient and counsellor talk about cancer; they have a mutual background of terminal disease. The term 'cancer' might be an important clue, which is relevant to death or fatal disease. Thus, the counsellor picks up on this word as a key to address death directly. In addition, the counsellor refers to the name of another patient— Nongkran who died of AIDS as shown in line 20. The counsellor uses body language in lines 24-26 by moving forwards to the patient and touching the patient's leg when she mentions death. Lines 32-34 show the third feature, refocusing from a general address into a specific address. The counsellor reassures herself about how much death concerns the patient. The counsellor asks the patient '(you) are afraid of cancer (.) afraid of only cancer or also fear death'. The patient states that she is afraid of cancer because getting cancer encompasses great pain as shown in the last turn.

In summary, although counsellors are told to engage their patients in such a way that they talk first about their concerns and worries, sometimes, patients are too passive and they do not initiate the topics. As a result, these sensitive topics have to be deliberately raised by counsellors themselves. The way in which the nurse brings the topic up is to refer to death in general or the death of a third person. The patient initiated the topic of death or suicidal thoughts directly.

8.5.2 Response and consolidation

The second stage is referred to as response and consolidation. Both address death, dying or suicide in detail. Patients' responses can clearly and sensitively demonstrate what they think about their death. At this stage, patients exhibit

some strong emotions such as by crying. Patients cry when they are aware of dying to mark the topic as one of concern. In addition, patients cry when they feel sensitive, depressed, worried, anxious, fearful or insecure. Crying can indicate depression and nurses as counsellors can use it as a sign to detect or predict such problems and depression (see Carey et al., 1997, p.27). The nurse, in response to a patient's crying, delays the conversation to continue interaction. The nurse typically produces a gap and composes herself (see Hepburn, 2004, p.279). The nurse also uses non-vocal activities such as facial expression, touching, giving face tissues, or sympathetic action, such as embracing. These actions are considered sensitive and rather direct in the context of talking about death. However, some patients respond to nurses' questions in such a way that the nurse finds it difficult to probe further: patients construct blocking answers. These answers form an obstacle for nurses in terms of further following up. Nurses then have to struggle to deal with the topic and its development. Thus nurses have to find another way to probe the death of the patient. Other times, patients provide opportunities for talking about death. Thus nurses take those opportunities to be direct or allusive to the death of the patient in following sequences of talk. These indicate that responses produced by patients are highly correlated with what the nurses select in their turns at talk. Here I show some examples of the response and consolidation.

8.11 [08 – 11:10] [VIDEO]

[The counsellor was a psychologist. The patient was a widow. Her husband committed suicide by shooting himself dead. The patient was on the ARV programme.]

- | | | |
|-----|----------|------------------------------------|
| 1. | Patient: | when husband died |
| 2. | Nurse: | uh (.) uh |
| 3. | Patient: | he did not die because of this (.) |
| 4. | | he killed ((relaxing body)) |
| 5. | | → himself ((laughing)) |
| 6. | Nurse: | → err: he [killed himself |
| 7. | Patient: | [he told me (.) he told me |
| 8. | | that (0.1) he did not want me |
| 9. | | ((moving hand)) to (.) what he |
| 10. | | said ((pursing hand)) look after |
| 11. | | when he was ((moving hand around)) |
| 12. | | ill |
| 13. | Nurse: | ((tossing head)) uh ((tossing |
| 14. | | head)) uh ((tossing head)) uh |
| 15. | Patient: | wipe (.) shit (.) wipe (.) piss |
| 16. | Nurse: | ((tossing head)) uh ((tossing |

17.		head)) uh like that
18.	Patient:	he did not want me to suffer
19.		something like that

In case no. 08, at 11:10 minutes, the counsellor and patient discussed the death of the patient's husband profoundly. The patient told the nurse that her husband committed suicide. One aspect that should be underlined is that the patient laughs when she reveals that her husband killed himself instead of dying from AIDS, as illustrated in line 5. Laughing in this context does not indicate amusement, as it may superficially appear. Laughing as it is used here relates to trouble-talk.

Jefferson (1984b) states that a trouble-teller produces utterances and then laughs. The counsellor as a troubles-recipient does not laugh, and demonstrates her understanding of the prior turn by producing a recognizably serious response. As shown, the patient produces a laugh at the end of her turn. In line 6, the counsellor repeats what was said by the patient in the prior turn in stating 'err: he [killed himself]'. Next, the counsellor and the patient talk about the history of her husband's death before the counsellor addresses the thoughts of the patient herself about suicide attempts. This kind of talk can be seen as sensitive and direct. The patient reveals that her husband had had suicidal thoughts all the time, but she had been unaware of them even though her husband alluded to his death and gave some clues. All this is revealed by the patient herself in counselling. In addition, before the patient's husband shot himself, he had tried to tell his wife that he was going to die. Again, this was ignored by his wife.

The following example shows the counsellor discussed death in relation to finding out whether the patient has thought of suicide. This case illustrates the way in which the counsellor makes an attempt to be allusive to death by using different questions in the stage of response and consolidation.

8.12 [18 – 17:07] [VIDEO]

[The counsellor was a midwife. The patient was single. He was on the ARV programme.]

1.	Nurse:	((uh)) ((nodding)) ((looking down))
2.		→ are (you) °alone°
3.	Patient:	((shaking head))
4.	Nurse:	→ °lonesome°
5.	Patient:	no ((wiping forehead)) have got
6.		some friends there

7.	Nurse:	no (.) inside ((tapping chest))
8.		((tapping chest)) mind
9.	Patient:	((shaking head)) not lonesome
10.	Nurse:	your heart (.) feel [that
11.	Patient:	[relaxing
12.	Nurse:	alone (.) something
13.	Patient:	((shaking head)) nothing
14.	Nurse:	and are (.) stressed
15.	Patient:	((shaking head)) not stressed

At 17:07 minutes, the counsellor uses formulation. She probes again to find out whether the patient thinks of suicide, but this time she uses another tactic; the counsellor alludes to suicide by using the concept of 'being alone' and 'being lonesome'. Connected to this concept is the fact that if one becomes alone and isolated in the wake of a crisis, he or she might think about suicide as shown in lines 2 and 4. The counsellor modifies questions by asking the patient whether the patient was stressed or not. It can be seen that in talking about suicide, the counsellor does not end the discussion early. But she goes round the topic.

The next example shows the patient is emotional when she worries about the premature death of her son.

8.13 [36 – 27:13]

[The counselling was held at the patient's home. The patient was a widow, and single mother. She is living with a son; her son was infected. She had given up taking ARVs, but she has now restarted them.]

1.	Patient:	°I pray for (.) ask for (.) not be
2.		like that°
3.	Nurse:	uh (.) uh
4.	Patient:	((putting down a doll)) ((touching
5.		face))
6.	Nurse:	°uh (.) uh°
7.	Patient:	((crying)) ¹²⁷
8.		(2.0)
9.	Nurse:	→ ((moving forwards)) ((caressing
10.		the patient's back)) ¹²⁸ (1.0)
11.		→ ((touching the patient's
12.		shoulder)) this thing can be
13.		sorted out (2.0) ((touching the
14.		patient's leg)) °one day (.) he
15.		→ might be lucky that
16.	Patient:	((drying hand on pants))

¹²⁷ The patient is crying and wiping tears continuously until line 15.

¹²⁸ The way in which the nurse produces body movement is by slowly caressing the patient. Then the nurse touches the patient's shoulder still and caresses the patient's right arm and lets her hand stay on the patient's arm. The nurse retracts her hand at the end of line 13 to touch the patient's leg, as shown in lines 13-14.

17. Nurse: → there are some medicines and
18. something for son right^o

In example # 8.13, the patient is crying as she thinks about her son's possible death. The patient told the nurse that she worries that her son's infection might be revealed at school. She prays for what she worries about not to happen. The nurse encourages the patient by using body movements such as touching and caressing the patient's back and shoulder, and touching the patient's leg (lines 9-15). Then the nurse enters into the context of ARVs as shown in line 17.

I should discuss further what the data showed regarding the counselling theory and the practice. My data demonstrate that gender might be regarded as important in determining the use of non-verbal communication. In other words, throughout this study, most female counsellors seem to be quite tactile with female patients, but less so when they are counselling male patients.¹²⁹ In this area, this case can confirm this statement. When the patient is crying and sensitive during the talk, the nurse touches and even embraces her. However, although touching is often found in many counselling cases, embrace is not found in any counselling sessions with male patients. The action of embracing is not included in the theoretical knowledge on counselling. This action should be referred to as 'sympathy' rather than 'empathy', which good HIV counselling practice advises against.

The data in real practice show clearly that nurses implementing theory in this study have often sympathized with their clients and that sympathy can aid the proper enactment of HIV counselling in the Thai context. Sympathy is not displayed in only one or two counselling sessions, but in several sessions. Consequently, it may be claimed that sympathy has a practical use in Thai HIV counselling. Further discussion of the application of empathy and sympathy in real counselling sessions follows.

First, sympathy exists in the Thai counselling context. The data clearly illustrate the adoption of sympathy in counselling rooms, and at patients' homes in a few cases. I should remark that such application does not render the counselling strange or inefficient in the Thai context. It could be claimed that

¹²⁹ The ethnographic data also show that nurses touch, stroke and caress the female patients and male homosexual patient who identified themselves as feminine. But they do not do the same with most male heterosexual patients.

sympathy is useful in some cases, especially when nurses have to discuss sensitive topics. Counsellors show their sympathy in verbal form and through body language, such as facial expression, touching and embracing. Using sympathy can make patients feel secure, and not on their own when some sensitive subjects are raised and discussed. It also encourages patients to have a more positive attitude towards their existence.

Second, although HIV counselling theory, based on the western model, has been designed to be flexible and applicable in several developing countries, contextual aspects should not be forgotten. Thai counselling is conducted in the real Thai context: Thai language, Thai belief, Thai social structure, Thai values and Thai thought processes. Thus cultural and other Thai aspects must be taken into account. For example, the cultural aspect of the degree of privacy in Thai rural areas must be highlighted because it shapes counselling in the way that it appears partly, in this study. Some of the patients' relatives may be present in counselling sessions. In addition, some Thai rural people are very timid, passive and reserved. Thus counselling in this area must not be very challenging or aggressive, but soft, sensitive and optimistic.

Third, it is arguable that most counselling theories are based on western models in western countries, where people are quite well-educated, more private and more active. In addition, the government in those countries provides more social welfare to citizens in comparison to the government in Thailand. Thus western patients might have less need for sympathy from their counsellors. They might need only health care counselling. For Thai patients, counselling themes raised in sessions are not confined to only health care, but also a wide range of aspects such as disclosure, sexuality, HIV patient network, emotions, family and community.

Fourth, most patients are financially poor. Thus economic status and children's education are often raised as important themes in sessions. Some patients demonstrate strong emotion when they are concerned with their health and children. It is impossible to discuss merely health care in long sequences of health conversation. Thus, in the meantime, some patients might need sympathy, coupled with empathy from their counsellors for encouragement.

Fifth, it appears difficult for nurses to be brought to the view that they should promote the autonomy and problem-solving skills of the patient. This

concept is more appropriate to a western context. In the Thai context, nurses sometimes have to dominate the patient and apply subtle power in order to forcefully coach their patients. In some cases, the conversation between a nurse and a patient in a private institutional setting appears to be a student-teacher relationship. Using such power might seem negative in some settings but in a Thai setting the client is passively coached by the nurse. Thus the term 'power' is applied in a supportive sense with a supportive meaning. In addition, such domination by the nurse renders counselling in the Thai context unique, but efficient. Institutional interaction is constructed and produced according to particular theoretical knowledge and the power lying behind it. These are applied through particular Thai social structures such as occupational role, social status, educational level and basic Buddhist characteristics that are adopted amongst Thais as common-sense knowledge in a way. Considering these social concepts, the application of power appears reasonable in some settings, and importantly such use of power might be forgiven to some extent especially as long as nurses can make patients feel secure and live longer.

In summary, the nurse and patient discussed death profoundly. Emotion was demonstrated at this stage of talking about death. The nurse uses different questions to allude to the death of the patients themselves. This is not always clear in this stage but becomes clearer in the next stage of talking that is the refocusing from a general address into a specific address.

8.5.3 Refocusing from a general address into a specific address

The third stage is critical because it applies directly to talk about death, dying and suicide with the patient. It is called the stage of refocusing from general address into a specific address. This stage is used by a nurse when she needs to know how her patient conceptualises the idea of death and dying. Nurses wish to know whether their patients have any suicidal thoughts and/ or made any suicide attempts. Through the use of this stage, the nurse makes an attempt to assist her patient in finding an appropriate solution. In addition, the nurse tries to make her patient reject the idea of death or suicide. At this stage, there are many tactics applied to each turn of talk. For example, a nurse may use a tactic of downgrading death, in order to render death less terrifying. Moreover, the nurse

reformulates death by naturalising it. Sometimes, the nurse uses metaphor. In some cases, patients themselves use a tactic of fatalism, naturalization or fake realism towards their own death. Naturalization and fake realism are referred to in the context of Buddhism. In addition, some nurses find it useful to ascertain whether patients remain positive and optimistic about their future. The Buddhist concept used in HIV counselling might reassure a counsellor that a patient has already kept himself or herself distant from suicide.

This Buddhist belief is that birth, ageing, pain and death are parts of the life cycle. Significantly, this implies that a patient regards or considers death as normal and natural. When nurses make attempts to allude to the possibility of suicide, the question is how the nurses can be reassured that their patients ignore suicidal thoughts. They encourage their patients to talk about what the concept of death is in the meantime. Additionally, having discussed death, dying and suicide in this stage, it seems that some patients have been prepared and facilitated for exiting from the conversation.

The first example shows the counsellor uses an indirect question to refocus from addressing the death of the patient's husband into the patient's death.

8.14 [08 – 17:22] [VIDEO]

- | | | |
|-----|----------|--------------------------------------|
| 1. | Nurse: | ((tossing head)) could sleep |
| 2. | Patient: | could sleep all night long because |
| 3. | | I do not worry anything much |
| 4. | | family members (.) they look after |
| 5. | | [me |
| 6. | Nurse: | [((nodding)) look after well |
| 7. | Patient: | well (.) ((nodding)) ((nodding)) |
| 8. | | uh (.) nobody discriminates |
| 9. | | against |
| 10. | Nurse: | → ((nodding)) uh ((shaking head)) do |
| 11. | | → not think of suicide like (the |
| 12. | | → name of the patient's husband) do |
| 13. | | → you ↑right? |
| 14. | Patient: | → ((shaking head)) ah:: |
| 15. | | → ((laughing)) no ((laughing)) |
| 16. | | → ((touching under nose)) |
| 17. | | → ((sniffing)) not at all |
| 18. | Nurse: | how (.) uh |
| 19. | Patient: | uh ((drying tear)) do not think |
| 20. | Nurse: | uh |
| 21. | Patient: | → think that ((nodding)) oy:: when |
| 22. | | → it is time (.) die on it own |
| 23. | Nurse: | uh ((---tossing head 5 times---)) |

24. right ((nodding)) this reason is
 25. right
 26. Patient: uh

At 17:22 minutes, the counsellor asks whether the patient could sleep or not. The nurse uses an indirect question with the word 'sleep' as a clue. The patient told the counsellor that she could sleep because she did not worry about anything much; her family members look after her. The patient's reply seems not to be what the counsellor needs. Consequently, the counsellor refocuses from talking about the husband's death into a specific address of the patient's suicidal thoughts by directly stating '((nodding)) uh ((shaking head)) do not think of suicide like (the name of the patient's husband) do you ↑right?' (lines 10-13). The counsellor uses the form of a tag question in order to be assured that her patient has no intention to commit suicide. It appears that the patient denies having any suicidal thought by stating '((shaking head)) ah:: ((laughing)) no ((laughing)) ((touching under nose)) ((sniffing)) not at all' in lines 14-17. This kind of answer is not elaborated in terms of details, and can be regarded as an obstacle for the nurse. The counsellor just produces an agreement stating 'uh' in the next turn. In lines 21-22, the patient considers death as natural: she will die when it is time to die.

In this case, the patient seems not to worry about her infection. She is asked questions relevant to suicide because her husband had committed suicide by shooting himself. Consequently, the counsellor is afraid that the patient may have thought of suicide as her husband did. The patient shows that she did not have suicidal thoughts by considering death as a natural: she will naturally die when it is time to die.

The following example shows the nurse refocuses from the death of the third person into the death of patient herself by applying the counselling theory.

8.15 [09 – 06:06] [VIDEO]

[The patient was a widow. She is living with her daughter. Her daughter was not infected, but had been diagnosed with a leaking valve in her heart and narrowed aortic valve heart disease. The patient was on the ARV programme.]

1. Patient: many things ((sniffing)) ((tidying
 2. hair up)) the doctor said many
 3. things (.) but the major problem
 4. is .hhh (0.2) heart valve leaking

5. (.) narrowed aortic valve
6. ((raising hand to chest)) also
7. (0.2) the doctor said ((wiping
8. forehead)) in case (.) operation
9. must be done twice
10. (3.0)
11. Nurse: → °you worry in terms of being alive
12. → ((nodding)) of daughter°
13. ((nodding))
14. Patient: uh ((drying tears))
15. Nurse: → >or you worry about something
16. else<
17. Patient: both my own matter (.) daughter's
18. also¹³⁰

At 06:06 minutes, the nurse would like to know about what really concerns this patient between her daughter's premature death and her own death. The nurse produces a conjunction 'or' in her turn as shown in line 15. The purpose of using this utterance is to introduce another possibility for discussion, which is the death of the patient herself. Furthermore, in this case the theoretical knowledge being used by this nurse is clear. She uses a technique of HIV counselling¹³¹ by paraphrasing what the patient said in the prior turn. In lines 11-12, the nurse designs her turn by stating '°you worry in terms of being alive ((nodding)) of daughter° ((nodding))'; this is paraphrased from lines 3-5 in example # 8.7. The use of paraphrasing helps the counsellor maintain the same meaning as the prior turn designed by the patient. This is a nurse's tactic to make empathy possible.

Empathy is a central concern of counselling. If empathy is considered according to the western theoretical models, it should be applied in counselling in preference to sympathy, in order to encourage the patient to become more independent. In my data, this empathy might be removed from theory. In practice it might be compromised because it has sometimes been replaced by sympathy.¹³² However, empathy is possible in Thai counselling. Roger (1975), Nelson-Jones (1988) and Silverman (1997) point out that a technique used to make it possible is the use of turn at talk (see Silverman, 1997, p. 221). In such use of turn at talk, the counsellor demonstrates empathy through the use of paraphrasing. Although counsellors should empathize, they also need to control their own emotions.

¹³⁰ At 12:46 minutes, the nurse and patient discussed the death of the patient and the patient's daughter.

¹³¹ See this technique in Chapter One.

¹³² At 21:44 minutes, the video shows that the nurse applies the sympathy by embracing the patient.

‘Counsellors should find the correct balance between detachment and closeness in order to promote the autonomy and problem-solving skills of the client’ (WHO, 1994b, p. 28). This indicates that counsellors should show neutrality as much as possible.

In case no. 17, the nurse and patient discussed how the patient plans for the future of her daughter, who is also infected with HIV. Then the nurse refocuses from the death of the patient’s daughter into the death of the patient by using a hypothetical question.

8.16 [17-50:06] [VIDEO]

[The counsellor was a midwife. The patient was a widow, and a single mother. She was on the ARV programme. One of her children was infected.]

- | | | | |
|----|----------|---|---------------------------------|
| 1. | Nurse: | → | ((moving hands)) if one day you |
| 2. | | | are not healthy to work |
| 3. | | | (4.0) |
| 4. | Patient: | → | means ‘die’ |

At 50:06 minutes, the counsellor uses another question ‘if one day you are not healthy to work’. This is a hypothetical question. Peräkylä (1993) found in his study that a hypothetical example can be used to lead to the dread discussion. In the forgoing example, the counsellor uses the grammar of an ‘if’ clause in line 1. The patient hesitates to answer this question. She produces a pause (4.0) in her turn before she uses a repairing technique to respond to the nurse’s turn. She repairs by stating ‘means ‘die’ (in line 4) in order to clarify what the prior turn of the counsellor means.

In my data, hypothetical questions are also often used to address the topic of death. There are many patterns of such questions, which enable the counsellor to find out about the patient’s concerns. The following are the patterns found in counselling sessions.

- a: Have you already thought about if one day you no longer live in this world to whom will you leave your children?
- b: If one day you are not able to work or if one day you are not healthy enough to work.
- c: If one day you are ill and if you have symptoms (with a clue word such as ‘deteriorate’).

The next sequences show the counsellor's success in obtaining an answer for how the patient prepares for the future.

8.17 [17 – 50:15] [VIDEO]

- | | | |
|-----|----------|----------------------------------|
| 1. | Nurse: | means (.) one day if you are ill |
| 2. | Patient: | ((nodding)) ((nodding)) |
| 3. | Nurse: | if you have symptoms (1.0) |
| 4. | | → deteriorate |
| 5. | | (1.0) |
| 6. | Patient: | ((nodding)) |
| 7. | Nurse: | ((taking off glasses) have you |
| 8. | | already planned (.) for children |
| 9. | | ((moving hands)) who will look |
| 10. | | after |
| 11. | Patient: | ((nodding)) ((nodding)) |
| 12. | | ((nodding)) mum will look after |

At 50:15 minutes, the counsellor uses the word 'deteriorate' in line 4 to allude to the discussion of the future after the patient dies. The counsellor is concerned with who will look after her daughters. She tries to help her patient find a resolution. Finally, the counsellor has had a satisfactory answer that the patient's mother will be responsible for her daughters. This example illustrates how the counsellor may use many questions to talk about death and how the patient prepares for their own future and their children's future.

In this case and in others, the use of different questions is seen when the nurse makes an attempt to find out what really concerns the patient and whether the patient thinks of suicide or not. The nurse does not definitely use a particular question. Instead the nurse modifies the questions she uses as she goes round the topic until she has elicited sufficient detail from the patient. The nurse alludes to death throughout the discussion.

The following example shows the nurse brings the topic up by using an indirect question. The nurse applies a cultural question allusive to the death of patient herself. The use of a cultural question can elicit more information on what a patient thinks regarding death and suicide, but the nurse must be in the same cultural context as the patient. This means that the nurse has to know what kind of activities a patient is likely to have participated in, such as funerals. Thus, this question applied to HIV counselling is truly based on cultural participation.

8.18 [19 – 07:05] [VIDEO]

[The patient was a widow. She was on the ARV programme.]

1. Nurse: then ((pointing towards patient))
2. (you) participated in ((moving
3. hand)) funeral (0.2) funeral as
4. today of your friend (.) who
5. passed away (0.2) saw it
6. ((touching chest)) feeling
7. ((tapping chest)) ((---nodding 3
8. times---)) ((stretching hand))
9. your feeling ((moving hand
10. around)) how do feel?
11. Patient: nothing (.) now
12. Nurse: ((clasping hands together))
13. → ↑nothing?
14. Patient: ((nodding)) right (.) nothing (.)
15. but ((touching chest)) previously
16. ((moving hands) when I had gone
17. to funeral (.) I every time CRIED
18. Nurse: cried (.) because
19. Patient: that's because ((touching breast))
20. (I) feared myself
21. Nurse: ((nodding))
22. Patient: ((moving hands)) only feared death
23. ((smiling))
24. Nurse: ((smiling)) ((nodding))
25. Patient: left daughter behind (.) thing
26. ((moving body)) which I concerned
27. the most (0.1) was daughter (.)
28. worry about the future

In example # 8.18 the nurse asks how her patient feels after having participated in another patient's funeral. This kind of question does not only lead easily to talk about death or dying or whether the patient fears death, but other concerns are provided in response to the counsellors' question. How patients construct the meaning of death, how they prepare for death emerges as issues to be addressed. Patients also elaborate more to nurses in terms of how they feel about the loss of friends. The nurse probes further because she is provided with a short answer. In line 13, the nurse repeats what the patient said in the prior turn stating 'nothing' with a higher tone in order to emphasize that the patient really has had nothing. At the end of the sequences, the patient told the nurse that she worries about her own death and her daughter's future.¹³³

¹³³ The same nurse employed this question in another case. The following excerpt from case no.20 shows the use of this question with another widowed patient at 22:39 minutes.

1. Nurse: err:: ((moving hand)) today (.) participated in funeral of friend (.) how do
2. feel?

The following example shows the nurse refocuses from the death of the patient's son onto the death of the patient herself by using an indirect question. However, the nurse still continues talking about the death of her son.

8.19 [36 – 29:31] [VIDEO]

[The counselling was held at the patient's home. The patient was a widow, and single mother. She is living with a son; her son was infected. She had given up taking ARVs, but she has now restarted them.]

1. Nurse: ((moving legs))¹³⁴ ((stretching
2. body)) when (the patient's name)
3. think that future is uncertain
4. right () as everyone
5. Patient: right
6. Nurse: → when one was born (.) they have to
7. Patient: ((holding face tissues ((looking
8. down)) ((sniffing))
9. Nurse: → then one has to die right
10. ((tossing head))
11. Patient: ((nodding))
12. Nurse: → how far can (the patient's name)
13. → accept? ((stretching hand))
14. → (.) how do (you) plan for your
15. → life? (.) how do you plan for
16. → your son and ((moving hand))
17. → (the patient's name)?
18. Patient: ((touching the floor)) I think
19. that (0.1) if anything happens to
20. (son) first that day (0.1) my life
21. will no longer either (.) the day
22. ((wiping eye))
23. Nurse: (uh) (uh)
24. Patient: the day that I have no son
25. → ((sniffing)) ((crying))

At 29:31 minutes, before the nurse asks the patient about how she accepts her future, the nurse naturalises the death. In lines 6 and 9, the nurse uses the universal truth that when everyone who is born ultimately will die. This formulation helps the nurse prepare the patient for a discussion about her uncertain future which the patient must confront. Then the nurse asks the patient how far she acknowledges her death and how she plans for herself and her son in lines 12-17. The patient responds by stating that if anything happens to her son,

3. Patient: was sorry too (0.1) but I do not want ((slightly smiling)) to mention

¹³⁴ The nurse and the patient were sitting on the floor. The nurse has gradually started moving her legs at 29:29 minutes in order to change her position of sitting.

she will no longer want to live. The patient often uses a strong emotion by crying to stress that what she says is important in line 25.

In this stage, the counsellor uses an indirect question with some clues which allude to the topic of death. This kind of question can help the counsellor assess what the patient thinks about death. The counsellor may ask a patient 'has he or she planned for himself or herself, children, families and the future'. This kind of question is the most frequently found in counselling sessions. In some cases, clues are used to allude to issues related to death, dying and suicide. Clues, such as sleep, can be used in relation to the death. In some cases, the nurse asks her patient whether he is sleeping well. This kind of question can lead the counsellor to understand whether her patient is worried.

In summary, the way in which the nurse refocuses the topic is by using indirect questions, though the topic has been already grounded in the previous stages. In this stage, the nurse may employ an indirect question accompanied with a hint or clue such as 'sleep'. The nurse may use a counselling technique of paraphrasing. A hypothetical question with a clue such as 'deteriorate' is also used in this stage. The cultural question of participation in a funeral is sometimes used to refocus from a general address into a specific address. In addition, the use of indirect question such as how the patient plans for the future is also found in my data.

8.5.4 The exit from the context of death

Fourth is the exit from the context of death, dying and suicide. In all cases, an optimistic or positive exit is used in ending a talk on death, dying and suicide. The nurse encourages her patient to live longer by stating that life is still hopeful, and that the patient should start a new life. In some cases, ARVs are referred to as one of the treatments to make the patient stronger in the future. The nurse encourages the patient to think of someone whom they love. Sometimes, the nurse finds it difficult to exit from the context of death and it is hard to move to another context of talk. Thus the nurse has to know how to manage the reaction given by her patient. In addition, in some cases, there is also an acceptant exit. The term 'acceptant' is related to Buddhism. Patients have been coached by their counsellors to regard death as natural, and to accept death calmly. Ariès (1974)

reviews western attitudes towards death from the middle ages to the present. He states that nowadays doctors and medical staff including nurses are the masters of death. They try to obtain from their patient ‘an acceptable style of living while dying’. This indicates that medical staff try to make their patient accept death. An acceptable death is a death which can be accepted or tolerated by the survivors (ibid, p.89).

In this stage of talking, it would be incomplete to not include the way in which a nurse gives her patient hope. This kind of action is frequently produced outside the context of death, but it can be considered in relation to death and suicide if it is applied to counselling. In most cases, data from the sequential organisation of talk illustrates how the nurses give patients hope. A nurse uses herself as a trustworthy confidant to build a supportive dependency: a patient can come to see a nurse at anytime. Furthermore, a nurse also gives a patient alternatives: a patient can call them at anytime if he or she can not come in person. These actions might make a patient feel valued and wanted. Some nurses use imperative forms such as come here or ring here. I should reiterate that nurses did not use other forms of grammar such as ‘should ring’ because the use of the imperative form provides a sense that ‘the patient is always welcome’.¹³⁵ What is more, they are so important that they have to be ordered to come over there.

The first example shows the counsellor exits the context of death by applying the Buddhist belief that nobody can avoid death.

8.20 [08 – 17:45] [VIDEO]

[The counsellor was a psychologist. The patient was a widow. Her husband committed suicide by shooting himself dead. The patient was on the ARV programme.]

- 1. Nurse: → nobody is greater than
- 2. Patient: ((touching eye))
- 3. Nurse: → a coffin
- 4. Patient: ((wiping eyelid)) ((nodding))uh
- 5. Nurse: → width is sok¹³⁶ (.) length is wa¹³⁷
- 6. → like that everybody dies (.) dies

¹³⁵ This happens in case no.23. At 26:58 minutes, the counsellor told the patient that the patient should ring her anytime as shown in transcript.

1. Nurse: this period of time, if you have got anything please come to talk or ring (.)
 2. come to see (the name of another patient).
 3. Patient: ((coughing)) right

¹³⁶ Sok is a Thai unit of length which is equivalent to half a yard.

¹³⁷ Wa or in Thai is a Thai unit of length which is equivalent to two metres.

7. → late (.) dies early (.) probably
8. → (.) someone (.) does not get AIDS
9. → ((nodding)) might die before us
10. Patient: ((nodding)) (uh)
11. Nurse: accidents suchlike

At 17:45 minutes, in lines 1, 3 and 5-9, the counsellor uses another tactic by employing a metaphor to continue this context. The counsellor compares the coffin as a symbol of death to one of absolute power. Although they are not infected with HIV, nobody can avoid death and finally one has to lie calmly in the coffin. In addition, the counsellor downgrades the severity of AIDS because other people might have a greater chance of death, even though they have not got AIDS. They might encounter other ways of dying such as a fatal accident. This means that getting AIDS does not prevent the patient living longer. This kind of technique remains optimistic. It has been used to terminate the sequence.

The following example illustrates another feature of exiting from the context of death. The nurse uses an optimistic exit.

8.21 [09 – 13:53] [VIDEO]

[The patient was a widow. She is living with her daughter. Her daughter was not infected, but had been diagnosed with a leaking valve in her heart and narrowed aortic valve heart disease. The patient was on the ARV programme.]

1. Nurse: → I believe that ((nodding))
2. → daughter must have long life span
3. Patient: ((---sniffing 3 times---))
4. Nurse: treat with (.) Doctor (the
5. doctor's name) is excellent
6. ((nodding)) after having operation

At 13:53 minutes, the nurse encourages the patient that her daughter should live longer. The nurse downgrades death in stating that she believes that the patient's daughter must have a long life span as shown in lines 1-2. The use of utterances like 'I believe that' is for exiting the conversation. In addition, in the same turn, the nurse employs a grammatical form in the modal verb 'must' in order to make her patient secure about the operation.

In case no. 23, the counsellor exits the context of death by referring to someone whom the patient loves. The nurse makes use of the patient's son and her parents.

8.22 [23 – 13:53] [VIDEO]

[The counsellor was a health educator. The patient was a widow, and a single mother. She was on the ARV programme.]

- | | | | |
|----|----------|---|------------------------------------|
| 1. | Nurse: | → | (the patient's name) please think |
| 2. | | → | of your parents ((pointing)) and |
| 3. | | → | your son ((pointing)) |
| 4. | Patient: | | ((tossing head)) |
| 5. | Nurse: | | try to ((stretching arms)) |
| 6. | | | concentrate (.) your mind (.) |
| 7. | | | all:::bring it there then you will |
| 8. | Patient: | → | I also think think like that |

In example # 8.22, the co-participants discussed the family. The counsellor makes use of family concern. She produces optimistic utterances by telling the patient to think of her parents and son (lines 1-3) to restrain the patient from a suicide attempt. These utterances are used to exit the context of death. In line 8, the patient accepts such optimistic utterances stating 'I also think think like that'. This indicates that the patient does not resist this optimistic projection.

In case no. 25, the data show that the counsellor exits from addressing death by applying an optimistic exit.

8.23 [25 – 28:15] [VIDEO]

[The counsellor was a health educator. The patient was a male homosexual aged 50. He was on the ARV programme.]

- | | | | |
|-----|----------|---|--|
| 1. | Patient: | | I did not want to get infected |
| 2. | Nurse: | | ((---nodding 3 times---)) ¹³⁸ right |
| 3. | Patient: | | if we knew ((moving hand)) it came |
| 4. | | | right ((moving legs)) I would have |
| 5. | | | prevented (.) right prevented |
| 6. | Nurse: | → | ((touching neck)) for this (.) it |
| 7. | | → | already happened (0.1) we start |
| 8. | | → | further new life (.) better |
| 9. | | → | ((tossing head)) ↓right |
| 10. | Patient: | | ((nodding)) right |

At 28:15 minutes, the counsellor prepares to exit from the context of death and move to another context. As is universal in HIV counselling, an optimistic exit has been used. In lines 6-9, the counsellor uses such an exit in stating '((touching neck)) for this (.) it already happened (0.1) we start further new life (.) better ((tossing head)) ↓right'.

¹³⁸ The nurse nods three times continuously.

In case no.36, the data show the nurse dissuading her patient from committing suicide. The nurse applies the positive construction to exit the context of suicide.

8.24 [36 – 30:10] [VIDEO]

[The counselling was held at the patient's home. The patient was a widow, and single mother. She is living with a son; her son was infected. She had given up taking ARVs, but she has now restarted them.]

- | | | |
|-----|----------|--------------------------------------|
| 1. | Nurse: | why do (you) think so? |
| 2. | Patient: | because my life and son's are the |
| 3. | | same ((louder crying)) ((drying |
| 4. | | tear)) |
| 5. | Nurse: | → ((touching patient's leg)) life is |
| 6. | | → still hopeful (the patient's name) |
| 7. | Patient: | ((shaking head)) |
| 8. | Nurse: | → ((moving forwards)) life is still |
| 9. | | → hopeful |
| 10. | Patient: | if I did not have a son (.) I |
| 11. | | would not be alive ((crying)) |
| 12. | Nurse: | (the patient's name) has got a |
| 13. | | cousin (.) is that auntie ↑right. |
| 14. | Patient: | ((shaking head)) ((sniffing)) |
| 15. | Nurse: | (do you) think ↑that (.) nobody |
| 16. | | will take care of him continuously |
| 17. | | something like that |
| 18. | | (3.0) |
| 19. | Patient: | ((sniffing)) I have not thought |
| 20. | | about it at all |
| 21. | Nurse: | but I think that a person who |
| 22. | | understands (the patient's name) |
| 23. | | is that auntie (2.0) ↑right? |
| 24. | Patient: | (right) ((nodding)) |
| 25. | Nurse: | have (the patient's name) ever |
| 26. | | talked with her about your ↑son |
| 27. | Patient: | ((shaking head)) never talked |

At 30:10 minutes, the nurse produces a descriptive positive statement (lines 5-6) stating 'life is still hopeful'. The patient responds with silence and produces only bodily movement by shaking her head. Lines 8-9 again show the way in which this nurse produces her turn using a positive construction, and this kind of action is found frequently in this case. The aim of talk constructed in this way is to naturalise death or downgrade death. The purpose of this step is to make the patient stay calm and positive towards the future. In this respect, the patient is also prepared to take the next step in talking about death. The nurse changes the image of death by showing that death is nothing and is slow; death can not do anything to her. The nurse characterises life as still hopeful, which means that

death has not yet come to the forefront. At the end of the sequences, the nurse moves into another context; she introduces the topic of family. The nurse makes an attempt to find out who will look after the patient's son in the future.

In summary, the topic of death is exited by the nurse. The nurse applies the optimistic and positive construction to end the topic. Counsellors have made attempts to allude to patients' worries regarding uncertainty, death, dying and suicide, and patients have rendered their own agenda visible, salient and adequately important for discussion to continue.

Here, I find it necessary to note further that in some cases, while there are many contexts revolving, the counsellor has her own technique to revisit or reformulate issues that concern her patient which may be related to suicide. The purpose of using this technique is to confirm the precise issue of concern and help the counsellor not to forget it. The kind of descriptive statement used might make the patient talk more expansively about her concerns. The particular theoretical technique used by the nurse is a summarizing tactic. Summarizing is one of the theoretical counselling skills. WHO (1994b, p. 29) states that '[t]his is very much like paraphrasing in that it helps ensure that the counsellor and the client understand each other correctly'. Koetsawang (1999, p. 84) points out that the counsellor might need to review and specify important points in a session. It helps counsellors to precisely understand precisely what issues concern their patients. This should be noted that this tactic is not used in the immediate following turn, but in later sequences in the session. It is possible that the nurse has to wait until all contexts have been addressed before using this tactic, which is then used to formulate the last action. The next example from the aforementioned case shows the use of summarising.

8.25 [36 – 37:56] [VIDEO]

- | | | | |
|----|----------|---|------------------------------------|
| 1. | Nurse: | → | conclusion is that (.) (the |
| 2. | | → | patient's name)'s problem is (1.0) |
| 3. | | → | the economic matter in the family |
| 4. | | → | right |
| 5. | Patient: | | ((nodding)) right ((nodding)) |
| 6. | | | right |

In lines 1-4, the nurse uses a summarizing tactic in stating 'conclusion is that (.) (the patient's name)'s problem is (1.0) the economic matter in the family right',

which describes the patient's worries. This kind of technique is used to round up many different contexts of talk, and can enable the nurse to find out what most concerns the patient. Thus, the reason for not immediately following up a serious issue is clear. As mentioned earlier, the nurse does not immediately follow-up the suicidal thoughts and attempt of the patient because the nurse aims to do so at the end of the conversation.¹³⁹

In addition, in contextualised micro analysis of talking about death, I wish to discuss further the social status and communicative pattern in talking about death. I consider that case no.35 is abnormal; the ontological status of the patient, which is constructed through a religious institution according to Thai social structures, caused this patient to be superior to the counsellor in terms of status. Most medical staff are well-oriented to their knowledge in their institutional identities (Drew and Sorjonen, 1997) and thus, they are often the most prominent participant in any health conversation. In addition, in Thai society, most patients are passive. These concepts clearly indicate that health consultation should typically be dominated by medical staff. Although the conversation of this case is initiated by the nurse, it is affected continuously by the balance of power between the nurse and the patient. In the sequences of this conversation, the nurse does not entirely dominate the talk. Sometimes, the patient shows his own technique to exert his power. I discuss further how this case is different from other cases in two ways. First, I show how the power in this patient's status implies its importance in the consultation. Second, I compare this case to other cases.

First, I illustrate how this patient looks more superior than his counsellor. Although there is much literature illustrating how aspects of asymmetry have existed and intermingled in institutional interaction between medical staff and patients (Drew and Heritage, 1992 and Hutchby and Wooffitt, 1998), some patients might display an unusually active role in medical interaction. This particular case suggests that the patient plays a role which, according to Thai social structures, renders him superior to a nurse. This unusual counselling example shows that the patient, a monk who was diagnosed HIV positive, is not hesitant in asking the nurse some questions. Simultaneously, he

¹³⁹ This technique was also applied in case no.41 (see Appendix D).

asks for co-operation from his counsellor in terms of confidentiality, as described in the previous chapter, and this may be explained by the fact that the patient is more powerful than the nurse, even though the nurse can be regarded as more knowledgeable in this medical care setting. It is useful at this stage to summarise how this patient appears more powerful.

First, in the counselling session the patient asks a question at the end of his turn ‘what else do doctor want to ask ((moving fingers))’, as shown in chapter six, in example # 6.4 (lines 3-4, page 178). This was the only example of this type of question in my data.

Second, the greeting and pronoun used by the nurse to address the patient also distinguishes the social status of this patient from that of other patients. This can be seen and heard at the beginning of the first line of conversation where the nurse pronounces ‘*Namatsakan*’¹⁴⁰ as greeting to the monk. This utterance is used by the nurse to address only monks, and is not used with other people. In addition, when talking to other patients the nurse normally uses ‘you’ to address the patient to whom she is talking, but in this case she sometimes uses ‘Than Jao’, for example in # 8.5 (line 4, page 299), which means the servant of Buddha as illustrated. The patient, as he is in the monkhood, produces utterances which other people do not use in everyday life. When he would like to accept the turn of talk of the nurse, he uses ‘Buddha (god) blesses you’ instead of nodding or producing ‘uh’, ‘right’ or ‘yes’, which are found in conversations of other patients.

Third, the patient makes an attempt to balance his own knowledge and that of the nurse in discussing death and dying. As he is a monk, it might be that he is sufficiently knowledgeable in ongoing interactions on the aspect of dread. The patient has been oriented to religious knowledge at his religious institution. Thus he has been involved with teaching about the nature of mankind: birth, ageing, pain and death and the three characteristics composed of impermanence, state of suffering and soullessness. Interestingly, in each turn of his talk, it is clear that he often produces quite long sequences of conversation. This kind of action is rarely found in counselling between nurses and other more typical patients.

¹⁴⁰ In the original Thai it is นมัสการ [นมะคัสะการ]. This utterance is formally used to open the conversation.

Fourth, the nurse produces some prefaced utterances such as ‘I do beg your pardon’ before she mentions death, for example in # 8.4, in line 41. In addition, in addressing this topic of death, she produces a characteristically Thai body movement. She puts the palms of her hands together, and politely bends her head. This action is called ‘*wai*’. It is an important gesture to be used when the speaker has to apologize or preface delicate issues.

Second, I compare other cases to counselling case no. 35 and how the nurse addresses death and dying. At this stage, details are elaborated in three areas as follows.

First, in order to address death with one patient, the nurse refers to the death of a third person. In other words, the nurse initiates the topic of death and dying by addressing it in general or in the impersonal form. The nurse will not directly attribute death to the patient. This kind of tactic is effective because it can bring the topic of death into the discussion gently.

Second, non-verbal communication or body movement can differentiate between the way the issue of death is addressed in case no. 41 compared to case no. 35. In case no. 35, the nurse does not touch the patient because he is in the monkhood, and according to Buddhist monks’ regulations and disciplines, no woman can touch a monk. This shows that the nurse adopts this discipline, and consequently she does not touch the patient, illustrating the social status between the nurse and the patient. Furthermore, the way in which the nurse uses her body movement is very reserved. By contrast, the body movement in case no. 41 is used more obviously. Before the nurse moves from addressing death in general terms into more specific terms, she touches the patient’s legs in lines 25-26 in example # 8.10. This kind of touch can be interpreted as the nurse wishing to make her patient secure before she mentions death as shown earlier. The patient should not be panicky, scared or worried about what the nurse is going to talk about as shown in lines 26-27 where she states ‘...I don’t mean (.) to make you [worry’.

Third, the verbal language used in the two counselling sessions is different. In case no. 35, before the nurse addresses the issue by mentioning the word death, the nurse uses some utterances such as ‘I do beg your pardon’ as stated earlier. By contrast, this kind of utterance is not found in counselling with

the patient in case no. 41, and other patients. This means that social status can determine the use of language and communication.

These cases provide an insight into the stages of talking about death. It shows how this trajectory has been initiated by the nurse by referring to impersonal death in the course of infection. Then the nurse refocuses from a general address into a specific address by alluding to how the patient plans for his future. In addition, this case is a representation of the episode of balancing between knowledge as power and status (see Schegloff, 1991) held by the nurse as counsellor and by the monk as a patient. Power and status are referred to in the context of HIV counselling under Thai social structure, which is strongly hierarchical. They have played a paramount role in shaping the counselling between these particular co-participants in an institutional medical context.

8.6 Conclusion

The data demonstrate that addressing issues of dread in Thai conversation in the context of HIV/AIDS is difficult and it should be conducted in an indirect way. There are three aspects of death referred to in counselling sessions: viz. the death of an individual, death of the patients themselves and suicide. The stages of discussion around death and dying talk consists of the opening of the topic, response and consolidation, refocusing from general address into a specific address and exiting from the context of death. The topic of death is mostly initiated by the nurse. The nurse sometimes initiates the topic by using cultural bodily movement such as putting the palms of hands together, which is known as the '*wai*'. Additionally, the nurse might employ an apologetic verbal form and a pause in initiating the topic. Referring to another dead patient was another effective strategy for introducing the topic. Some patients omitted a word clue for initiating the topic. In addition, the way in which the nurse and the patient rendered the topic sensitive is apparent in verbal utterances and gestures. Patients show awareness of dying by crying. The nurse responds to this by using lower or quicker utterances or touch. The nurse uses different questions to probe into any suicidal thoughts of the patient.

The data showed talking about death is not only interactional, but it is also managed in interaction through language in each stage of talking. The process examined is one in which nurses and patients have co-constructed social actions towards each other in the most basic form of organization of conversation-turn taking. Opportunities for a patient, as a lay participant in talking about death, dying and suicide are shaped by the way in which a nurse designs her turns at talk. These enable a patient to understand the issue, and may make it easier him or her to become involved in discussion about death, dying and suicide and be well-prepared towards it.

Chapter Nine

Concluding Discussion

'Indeed I've heard it said that we should be glad to trade what we've so far produced for a few really good conceptual distinctions and a cold beer. But there's nothing in the world we should trade for what we do have: the bent to sustain in regard to all elements of social life a spirit of unfettered, unsponsored inquiry, and the wisdom not to look elsewhere but ourselves and our discipline for this mandate' (Goffman, 1983, p.17).

Goffman's statement indicates that the story of human social life should be conducted without controlled or sponsored inquiry. I wish to emphasise that my study was undertaken without any specific interest group in mind. My study was not sponsored by patients, medical staff, NGOs or a government mandate. The methods and results presented should be both of academic and public interest.

It may seem strange that I travelled abroad to study language use in the context of HIV/AIDS in Thailand. That I should study HIV/AIDS in Thailand is straightforward because I knew the language, culture and other contexts. However, I chose to come to the UK because I wished to study something new to the social research community in my homeland. I chose to study talk-in-interaction by a scientific method that was very different from other social science research methods in Thailand. Before I applied this method to investigate the HIV/AIDS aspect, I had realized that much social scientific research and others had been conducted around HIV/AIDS in Thailand. I therefore used this new method of investigation to differentiate my study from the existing body of research. I decided to study HIV/AIDS counselling in Thailand by analyzing talk between the nurse and patient. I intended to describe what actually occurred in HIV/AIDS counselling in Thailand.

Before I discuss seven areas emerging from the study, I wish to emphasise that my study did not aim to evaluate the task of counselling nurses. But I would like to draw upon what the nurse did in counselling sessions. In the next section, first, I review how my study offers contributions to help address the AIDS crisis in Thailand. Second, I illustrate contributions to AIDS counselling in

Thailand and in general. Third, I show how CA is suited to my study. Fourth, I wish to illustrate how my access to data was unparalleled. I aim to show the main findings in the fifth area. Sixth, I explore the practical implications. Last, I discuss future directions.

9.1 Contributions to AIDS in Thailand

Up until now social research on HIV/AIDS social research in Thailand has been primarily concerned with prevention, and HIV/AIDS in the community. Most studies were conducted by means of survey and ethnographic methods, that is by the conventional methods of in-depth interview, direct observation, focus group and questionnaires. This summary and claim is supported by many sources.

First, I reviewed documentary sources (see Chapter One). Prevention is still the main core of content in social science research. Much literature looks at the sexual behaviour of a particular group which might be viewed as significantly associated with infection. In addition, many of the studies implied that young people should be oriented to a new concept of gender. This should lead them to understand more about gender, sexuality and the prevention of AIDS.

Second, I participated in the XV International AIDS Conference, where much of the social research on display was concerned with prevention and bringing awareness to people and the community. It is true that some Thai research has been conducted in the area of counselling, but those studies applied ethnographic and survey methods to data collection.

Third the summary is supported by ethnographic data in its own right. I talked to medical staff during the field work and I learnt that a doctor in one hospital studied social research by distributing questionnaires amongst counselling nurses. The nurses used one-to-one interviews to gather data from patients. In addition, another researcher also left questionnaires with counselling nurses. That researcher did not conduct the research on his own. This information seems to indicate that conventional social research methods are still dominant in the Thai research community. Conducting social research on AIDS in this way placed a burden on the nurses by increasing their work load. In contrast nurses

could help me conduct research simply by continuing with their routine tasks: they did not need to work harder or allocate more time.

I should emphasise that my study did not aim to show how prevention should be conducted or what kind of sexual behaviour is needed to avoid AIDS. My study was concerned with counselling in Thailand, to which I applied ethnographic methods such as in-depth interview, direct observation and the use of focus groups to understand AIDS treatment at the macro level. The most important data in this counselling study was the recording of consultation between the nurse and patients. I analysed those consultations which occurred naturally by the method of CA. My counselling study represents the first research in which talk in the context of HIV/AIDS was analysed by this new methodology in Thailand. Importantly, this study introduces CA to the Thai research community. I argue that these are the contributions given by my study, to the issue of AIDS in Thailand.

9.2 Contributions to HIV/AIDS Counselling in Thailand and in general

Little attention has been paid in the existing body of research to the study of counselling. There is still a shortage of counselling research related to the social aspects of HIV/AIDS. My study offers contributions to HIV/AIDS counselling in Thailand as far as the following aspects are concerned.

As well as increasing the number of studies of counselling, my study illustrates the practices and the implementation of counselling policy. Counselling nurses have been trained following an American model. They tried to adopt the concept of being neutral. Counselling sessions were held in medical settings, but from time to time it was necessary to conduct a session at a patient's home. This study illustrates the use of home services in the context of Thai medicine. In theory, the patient should be coached to be independent. The reality was that patients needed considerable support from their counsellor. One feature is that most HIV patients who came for treatment came to the medical setting not for the purpose of medical treatment, but also had other high expectations of

receiving aid beyond that provided simply by medicines. Thus, those expectations were brought into the discussion in HIV counselling. Some patients regarded their counsellor as their sole confidant. Some patients needed support on finance, children, education, career and employment.

In the medical settings I observed the way in which the patient was treated by medical staff. I found that patients from the rural area appeared passive. Decisions on care and treatment were made or provided by the medical staff. This contrasts with western countries, where patients were invited to get involved with treatment decisions, and were viewed as independent. Of course, this study did not evaluate the medical staff because medical treatment in the Thai context was so complicated. Most patients in the rural area were not well-educated, and they were rather poor financially. It is not common to find decisions made solely by patients themselves. They were concerned with many issues at home, such as the family economy, their children and their education. They were convinced of and trusted in the theoretical knowledge of medical staff. This indicates the asymmetry of information around medical knowledge in a rural area, and this imbalance shapes the interaction in medical settings.

My study helped illustrate the reality of patient-centeredness and counsellor-centeredness in the process. Patient-centeredness seems to be considered most suitable for HIV counselling according to theory. However, this patient-centered approach may not be practical to some extent in the Thai context. This is simply because the cultural aspects, people and social aspects are different. Patients may not feel able to initiate certain topics of concern, and they are more passive. Consequently, in the interests of achieving the goals of the counselling task counsellor-centeredness may be more practical on some occasions. The counsellor may reserve a role in asking the questions and an asymmetrical interaction exists in Thai counselling.

In addition, this study has highlighted practical counselling theory. The data showed the meaning of counselling. My study may form a reminder that it is time to redefine what HIV/AIDS counselling means in the Thai context. Such a redefinition could result in a real Thai counselling theory. Significantly, HIV counselling theory should be directionally built up from the real phenomenon of Thai counselling in practice, and the particular cultural contexts and social angles should form part of that theory.

This study could reflect the real characteristics of HIV counselling. Thai People and their cultural, social, economic and educational backgrounds, and social structures differ from people in western contexts, where most of the HIV counselling theory was originally constructed. This results in HIV counselling in Thailand being unique to the Thai context. For example, it is universally believed that empathy should be applied in HIV counselling, and this empathy can be seen in Thai counselling through the use of paraphrasing in some cases. However, some counsellors also automatically display a natural sympathy that plays an important role in achieving the objectives of the counselling task in the Thai context. This contrasts with the theory which advises that sympathy should be avoided in counselling. Thus, the question arises as to whether, in the Thai setting, the application of sympathy to counselling should be acknowledged and regarded as important rather than something to be avoided or overlooked. The data showed that the western theory or concept of empathy can not entirely be generalised to Thai counselling. This may indicate that Thai culture, in particular in the rural area, still influences the application of the western theory. In other words, Thai culture renders the western theory less powerful. CA uncovers the strength of Thai culture in dealing with the western guidelines.

Its use may be practical in encouraging some patients to have positive feelings towards their future, and it also constructs a warm interaction which may encourage patients to want to live longer to be with their children and family. It may restrain some patients from attempting an unexpected resolution of their situation, such as attempting suicide.

During the counselling training courses, counsellors had never been prepared to deal with some special patients, such as the monk who holds a different status. Indeed, counsellors have to talk with many patients who have a higher status than them. My study showed that dealing with a different patient may be difficult, and the counsellor needed a special skill in communication. The counsellor may need to know how to choose terms of address or proper body movement. This information should be remembered for HIV/AIDS training in the Thai context in the future.

This study has demonstrated many different aspects in counselling. Thus it should be relevant to the interests of medical staff and students. The findings can

be disseminated to inform them about counselling techniques or how to deal with HIV/AIDS in a medical institution. In particular, nursing students can use this study as a basic model.

My study also offers contributions to HIV/AIDS counselling in general. On the video recording we can see the emotion involved in counselling sessions. Some patients cried. In response to such emotion in face-to-face interaction such as the counselling in my data, the nurse applied counselling theory by using touching or stroking. In contrast in research on telephone counselling, it is impossible to see the application of counselling theory by using body movements. The analysis of data could be done by listening to verbal utterances and silence in order to study the emotion of the counsellor. In addition, my data showed body movements were significantly applied to restrain some patients from spreading the disease. For example, the nurse tapped a part of the patient's body. Of course this action could not be seen on the telephone counselling when it was analysed.

9.3 The use of the methodology of CA

Although I had planned to apply only CA to my study, this intention was changed. When staying in the research site, I talked to research participants and realized that I should apply ethnographic methods to help me understand more about the AIDS phenomenon. My study was thus a combination of CA and ethnography. I applied the sensibility of CA to study counselling data at an analytical level. I did not look at the practices of turn-taking in conversation between the nurse and patient as most conventional CA research normally does. Instead I applied CA method to analyse talk between the nurse and patient to discover how Thai counselling was conducted. I analysed the data on a turn-by-turn basis but the topics for detailed analysis were chosen on the basis of their prominence in the sessions and my understanding gained through ethnographic research. For example, I considered who initiated the topic of disclosure and confidentiality. Following this, I looked at the way in which the initiator introduced the topic. I did not consider what kind of turns the initiator produced. Instead, I tried to find out what kind of questions and language the

initiator used in their turn.

By using CA to analyse talk, my study has offered something practical to the Thai research community. Thai students study language such as grammar, words or sound rather independently. It was rather new for me to study language as social actions and a combination between sociology and linguistics. I studied counselling by analysing language as social actions in counselling; more specifically I looked at how things were conducted. Both verbal utterances, the way the utterance was used, and body language, for example gaze, gestures (touching, tapping, stroking, caressing, nodding, and tossing a head), display of body parts or crying, and facial expression in interaction were included in my analysis.

In the past, HIV/AIDS counselling research in Thailand has been conducted by ethnographic methods and quantitative research. In such research nurse and patient were interviewed independently at different times and in different contexts, and with different questions. In this way of conducting research, participants might give their opinions, attitudes and future expectations rather than describe what they have actually done in counselling. My study may offer something different by revealing to the readers the real world of the HIV/AIDS phenomena. In addition, this study presents a collection of true stories which patients told their counsellors. In particular some aspects such as sexual behaviour and conduct normally deemed private and confidential are described. It might be difficult to obtain such information by means of other research methods.

If I had applied other qualitative methods to study counselling, I might have been provided with answers that described the thoughts of nurses and patients. I did not want to know what they think about their counselling task or what they feel they should do in counselling. Neither did I want to know how patients felt about counselling services. Instead, I wished to know what they had actually done in counselling.

I wished to show how delicate issues such as sexuality, death, dying and suicide are initiated, discussed, managed and ended in conversation. I also wanted to know how advice-giving was conducted in counselling. As we are oriented to the sensitivity and taboo of talking about sexuality and death, I wished to find out the way in which the topic is rendered sensitive in conversation. I found out that it was sensitive because the nurses did not initiate

the topic directly. They employed particular questions such as a general question, to bring the topic up. They also used body movements to initiate the topic. CA revealed that the delicacy, sensitivity and awkwardness was handled and managed by the way in which the nurse employed indirectness and lexical choice to clarify things for the patient in terms of sexual conduct (see Chapter Seven).

9.4 Access to data

Access to data was possible owing to the willingness of doctors and nurses to get involved with my study. Nurses in particular helped me recruit patients. The co-operation offered by nurses provided insight into the data. It may be said that my access to data seemed to be unparalleled.

I managed to make use of direct observation and other ethnographic methods. The insight I obtained through ethnographic field work was overwhelming. Each ethnographic recording contributed significantly to my overall sense of how AIDS counselling was organized. It also provided me with a 'holistic' view of the role of AIDS counselling in the treatment of HIV/AIDS, and in the lives of both nurses and patients. I interviewed medical staff, patients and their relatives. The nurses made it possible for me to participate in both formal activities and non formal activities related to AIDS. The nurse took me along to visit patients in villages. I experienced the way in which patients lived and handled discrimination in villages. I learnt how nurses and patients co-operated to handle problems emerging from infection in the community. The visits were part of the service provided by the Thai health system. A nurse also took me to visit a girl who was in a coma; this patient passed away three hours after we left her home. I had a chance to observe the Buddhist funeral of a girl who died of AIDS in the rural area. In a clinic, I also helped nurses handle the dead body of a patient who had died from HIV, which I found to be a valuable experience. In addition, I saw the way in which the doctor and nurses carefully handled a newly born child.

I should note that my access to interactional and ethnographic data was different from other ethnographers. For example, Whyte (1943) showed

difficulties of language use during his field work in his classic ethnographic work. Whyte tried to adapt himself to fit to Cornerville by using the 'vulgar' language, but his attempt was not practical to his field work. Participants were interested in Whyte because he was different from them. But I did not adapt myself much in the research site. I worked without anybody's mandate in hospitals and the community. Although I sometimes did not understand the northern language which people used, any relevant discussions were later made clear by the nurses and other medical staff. Medical staff and patients understood my difference. This was reflected in the way in which they saw my presence in the research site. In addition, I should note that although I stayed in hospitals, I was not aware of medical staff being afraid that I might encounter their secrets. Organisations such as the health services may be concerned that their internal practices will be revealed (see ten Have, 2004). I was left independent and free to conduct this study and observe routine clinical activities, even though the directors, doctors and medical staff did not know in advance my study's result.

I was able to record counselling sessions on video. The data itself reflected the way in which the talk between the nurse and patient was very sensitive and confidential. Recording by video could be intrusive. But I was able to manage and was still able to obtain permission from nurses and patients. Video data were extremely useful at an analytical level. I could repeat it as often as I wished. I could capture verbal utterances, body movements and gaze in interaction. In analyzing and showing the data, I as a Thai speaker translated the discussions into English. When I showed English native speakers data on video, they could follow with English transcripts. During ICCA06 in Helsinki when I showed my data and English transcript, participants were not lost though the conversation was in Thai.

9.5 Main findings

The most important data were from talk between nurses and patients. Forty three natural counselling sessions were recorded on video, and 9 sessions were recorded by audio tape. Video recording was possible because nurses helped recruit patients and explained to patients the terms of confidentiality and the

protection of rights. The research participants consisted of 9 nurses and 53 HIV patients recruited by nurses. The patients included single male patients, single widowed patients, couples, heterosexual and male homosexual patients. A consent form was signed by all participants before data collection commenced.

Sessions were analysed by CA. I did not attempt to study what interested the nurses. Thus, they did not affect the way I collected and analysed the data. In addition, I did not allow what I learnt from ethnographic data and my social status or gender to play a part in interpreting the counselling process. I analysed the data in conversation as each turn indicates. The main findings from the empirical evidence are shown to answer the research questions as follows.

My first research question is what the structure of HIV/AIDS counselling is. CA studies overall organisation (see Boden and Zimmerman, 1991; Heritage, 1984; Peräkylä, 2005, and Robinson, 2003). The overall structure of HIV/AIDS counselling in the Thai context is similar to that shown in general consultation. However, Thai HIV/AIDS counselling is different from the general health care consultation in terms of the 'in between' structure of the counselling. In primary health care consultation, as stated by Byrne and Long (1976) or Robinson (2003), the consultations consist of six stages (see Chapter Four). In Thai counselling, the sessions were opened by greeting and health discussion. Then they were developed; there were many themes raised in each counselling session, and then the discussion was finally closed. However, the way in which the discussion was managed was cyclical, as shown in Chapter Four. I should note that Thai nurses did things in counselling which might not be done in western countries or that western people expect to see. The counsellor wished to know everything that was going on with her patient. In practice the counsellor and the patient discussed the topic of health, ARVs, family, economic matters, confidentiality and disclosure, sexuality, the prospect of death. The nurse initiated on one topic, but she followed up with another topic. Following this, the nurse switched to discuss another topic. The way in which the nurse initiated, managed and controlled the topic was cyclical. The nurse went around the topics. The nurse kept going back to issues which had not been resolved to their satisfaction. For example, the nurse talked about the delicate and sensitive issues such as sexual conduct and suicide. Some patients were asked the same thing many times (see Chapters Seven and Eight). This indicated the nurse reserved the

role of a health educator. In most sessions, the nurse wished to know whether the patient ate properly, and could cope emotionally. In some sessions, the nurse went around the topic with male homosexual patients, but in a blunt style. This reflected the hierarchy in Thai counselling. The counsellor balanced between bluntness and crude terminology. The Thai nurses put theory into practice, but it was not done in a linear fashion. The way in which the medical staff in western countries put theory into practice was in stages. In conducting the counselling in the cyclical way of a Thai counsellor, the topic might be opened by a greeting and on the topic of health, but it might be terminated by other topics unrelated to health.

In addition, in the contextualised micro analysis, I was allowed to see the influence of Thai social structure. For example, the data on video made clear how gestures were used under a hierarchical structure. In addition, terms of address such as *pii*, *nong*, *aunties*, *than jao*, *Buddha blesses you* or *namatsakan* were seen to be used. This led me to compare some aspects in the structure of Thai counselling with that in western countries.

First, in counselling theory, the nurse should encourage the patient to initiate the topic. However my data showed that although the patients were afraid of death and dying, they predominantly did not initiate the topic. Instead, it was initiated by the nurse.

Second, my data showed that the nurse referred to the death of a third person by mentioning their real name. In my opinion, this could not be done in the western context.

Third, my data showed that the nurses applied sympathy, even though the western theory underlines the importance of empathy. As the nurses were trained in an American model, she was taught to be neutral. She should encourage the patient to be independent. But the nurses in my data still reserved a dominant nursing role. The nurse was involved with the patient's concerns more than would be expected according to the theory. This included the patient's home visits in villages conducted by the nurse.

Fourth, I refer to the use of circular questions in the Family Systems Theory in the work of Peräkylä (1993 and 1995). The counsellor could encourage the patient to discuss a sensitive topic which concerned the patient

by asking questions across the patient's relatives or partners. For example, the counsellor may ask the mother of the patient to describe what concerned her son (see Peräkylä, 2005, p.877). This was not found in my data. Most patients were single and they came for consultations alone. In addition, most patients kept their infection confidential, thus these questions did not use in the Thai context.

The second research question is what actually happened in the practice of counselling, and what themes or aspects have been discussed in sessions and how those themes or aspects have been brought into discussion. There were several themes raised in counselling sessions. The co-participants discussed health care, emotions, the prospect of death, ARVs, family and community, financial circumstances, the HIV patients' network, disclosure and confidentiality, and sexuality. However, my study predominantly illustrated four themes which featured in most sessions. These were joining and selecting for the programme on antiretrovirals, disclosure and confidentiality, sexuality and the prospect of death. In each theme, the way in which the topic was initiated and discussed, and how that discussion was managed are shown as follows.

Joining and selecting for the programme on antiretrovirals: The nurses always initiated the topic of ARVs; they persuaded the patients to participate in the programme, and followed up some patients for adverse reactions to the drugs. The patients initiated the topic when they wished to request permission to take ARVs, and to respond to statements made by nurses. The criteria and conditions the patients needed to meet to gain permission to use ARVs were related to their physical condition for eligibility, blood tests and CD4 count, social responsibility, and being a role model of a successful user. Patients were told they had to find someone to be a witness to sign a consent form before they could participate in the programme. Thus they had to reveal their infection to someone close. This made them hesitate to participate in the programme because they did not want to reveal their blood test results. However, the nurse encouraged her patients to take part in the ARVS programme and helped the patient to hide infection. To some extent, the patient might be put at risk due to allergic reactions from taking ARVs. This chapter showed two sides of risk taking: patients were put at risk of other infections if they did not take ARVs, but they also put themselves at risk due to allergy if they took ARVS without the

necessary discipline.

Disclosure and confidentiality: Most patients were seriously concerned about the revelation of infection. Patients had their own reasons for secretiveness. The types of people to whom patients reveal their infection can be categorised as family members, neighbours, colleagues and sexual partners. Language and non-verbal communication are important means by which to maintain their confidentiality. The nurse always initiated the topic. The way in which the nurse initiated the topic was to use general questions, and move to specific questions, sometimes including a key word. In addition, a normal requesting question, such as whether the nurses could visit the patient at home, helped the nurse allude to confidentiality. The nurses sometimes used repairing questions to clarify the problem. Furthermore, cultural dimensions such as eating together and social participation were used in this context. The patients resisted telling others of their infection status. Patients used strong formulations, turning hypothetical into actual situations, balancing and paradox as their techniques for resistance.

Sexuality: Three aspects of sexual talk were covered in counselling sessions: the first is the managing of public health information-safe sex, the use of condoms and the spread of infection; the second is instructing and advising on sexual practices; the third is sex and well-being. The topic of sexuality is mostly initiated by nurses, and only occasionally by patients. Nurses and patients took turns to address this sensitive topic-their orientation to its sensitivity being manifested in the use of language and body movements. Patients use pauses and stretching of their body when they aim to talk about their sexual conduct. Four different types of question have been applied by nurses during talk-in-interaction. These are general questions, specific questions, allusive questions and hypothetical questions. Each question has its own particular characteristic to be applied with different patients and in different features of conversation. The pathway of talking about sexuality includes the entry to the topic, the matter of giving advice, exploration of the patient's knowledge and the exit from the context of sexual talk.

My data showed that the nurse overwhelmingly initiated the topic. The way in which she initiated it was in an indirect manner. The nurse employed different questions to raise the topic. The nurse might use a general question, a specific question, an allusive question or a hypothetical question. Sometimes, the

nurse might refer to a third person to initiate the topic of sexuality. In this stage, the nurse also pursued her scepticism about a patient's response if she was not provided with sufficient information about the patient's sexual conduct. In a few cases, the patient initiated the topic. The way in which they brought the topic into discussion was by issuing voluntary information or a statement (see Diagram 8 in Chapter Seven). The patients showed their intention to reveal his sexual behaviour. They used pause and stretched their neck and body to bring the topic into discussion. Some patients might address it bluntly. For example one patient asked for condoms from the nurse.

The nurses did something beyond their counselling role. The way in which they alluded to sexual conduct of the patient reflects the public health role. It seems that the nurses frequently did not believe their patient. The nurses did not stop after the first attempt. They pursued answer to question the issue by using different kinds of question. This is part of the public health role of the nurse in which she wishes to know everything about the patient's health.

The patients were encouraged to have safe sex for themselves and their family. The nurse exited from the context of sexual talk by applying an emphatic, persuasive and modified form. For example, the nurse used a modal verb such as 'must' to stress the importance of condom use. The nurse applied body language such as tapping, to emphasise that the patient should not spread infection. In addition, the nurses applied Buddhist belief to discuss the spread of infection. The nurses attempted to convince patients to realise spreading infection was a sin.

I have shown discussion about sexual conduct and other related issues emerging from a wide range of patients. Talking about sexuality led to further discussion. Here, it might be worth looking back at those cases. The difference in a nurse's communication on sexuality with different patients should be discussed more. The nurse communicates differently with male patients, female patients and patients identified as homosexual.

First, the nurse will use specific questions such as 'have you gone for girls', or any questions related to the local restaurant or brothel with a male patient. However, for male homosexual patients who demonstrate femininity, the nurse will use a question which relates to a sauna or bar. Thus the context of place or setting for specific patients can be referred to specifically in connection

to the identified gender of the patient being counselled.

Second, the nurse uses slang words with male heterosexual and male homosexual patients more often than with female patients. In addition, the nurse keeps up-to-date with the slang words used by some male patients. The words mentioned are things such as 'wanking' for masturbation, 'cases' for condoms or 'gang-bang' for an act where sexual intercourse is had with multiple partners simultaneously.

Third, the nurse uses gestures such as touching or tapping more frequently with female patients or male homosexual patients than with male patients. The nurse tapping the patient's arm and hand is clearly different between case no. 10 and cases no. 04 and 43. In case no. 10, the nurse tapped the patient's arm only three times, but the nurse tapped it five times and nine times respectively in cases no. 04 and 43. Both of cases involve male homosexual patients. This observation may possibly be explained on the basis of sequences of conversation, in the sense that the nurse taps her patient in correlation with the next turn design.

Fourth, the way in which the nurse refers to the person who uses the condom is different. In male homosexual cases, the nurse means the sexual partners who have the active role in the sexual relationship, but in heterosexual male cases, the nurse refers to the patients themselves who use condoms.

Finally, it is not an exaggeration to say that the level of intimacy involved with ending the counselling differs between types of patient. The data show that the nurse seems to be intimate and more close to female patients and patients identified as homosexual compared to male heterosexual patients. This can be seen from the use of humour. As seen in example # 7.21 on pages 251-252, the nurse picks on the patient over how he regards his sexual relations as normal and different from the way other people do. This is because he used to have four boyfriends, while the nurse has had only one husband, shown in the nurse's last turn in lines 43-46.

The prospect of death: Directly addressing issues of dread in Thai conversation in the context of HIV/AIDS was difficult. Most nurses initiated the topic in an indirect way. There were three aspects of death referred to in counselling sessions; notably the death of an individual, death of the patients themselves and suicide. The stages of talk about death consisted of introducing the topic, response and consolidation, refocusing from general address into a

specific address, and exiting from the context of death.

The nurse sometimes initiated the topic by using cultural bodily movement such as putting the palms of the hands together, which is known as the '*wai*'. The nurses also employed an apologetic verbal form and a pause in initiating the topic. Referring to some other patients who had died was also used as a way to introduce the topic. Patients rarely initiated the topic bluntly. In some cases, the patient referred to suicide if her son died before her. A female patient worried about the premature death of her daughter. A male patient referred to his father's death if he knew about the patient's infection. Some patients omitted a word from a sentence as a clue for initiating the topic. The co-participants discussed death in detail. Many patients displayed emotion by crying. In addition, the way in which the nurse and the patient rendered the topic sensitive was apparent in verbal utterances and gestures. Patients cried when they were aware that they were dying. The nurse used quieter or quicker utterances or touch in response to the patient's turn, and allowed the patient to cry for a while and offered comfort.

When the nurse refocused from death in general onto the death of the patient themselves, she used indirect questions in this stage of talking. For example, the nurse applied a question of how the patient had planned for his or her future. Sometimes the nurse used a question with a clue such as 'sleep' or 'deteriorate', to allude to the death of the patient. In addition, the nurse used a cultural question of participation in a funeral to discuss the death of the patient. In probing about suicide attempts, the nurse went round the topic and came back to discuss the issue in further sequences. The nurse did so in order to ensure whether the patient thought about it or not. If the attempt appeared clear, the nurse then tried to restrain her patient from suicidal thoughts. The nurse exits from talking about death by using a positive construction, preparing her patient to confront dying and death in the future. Buddhism was also applied to exit from the topic of death; Buddhist belief was used to make the patient view life and death as part of a cycle of life.

Here, I compare some aspects emerging from the data on addressing the sensitive topics of sexuality and the prospect of death.

Opening of the topic: The nurse initiates the topic of sexuality by using an indirect question. The patient initiates it by using pauses and stretching their

body, for example their neck. The nurse initiates the topic of death by using an indirect question. The patient initiates the topic bluntly.

Discussion: There is not much emotion displayed in addressing sexuality. The use of emotion is involved with the discussion about death.

The use of modified questions: The nurse probes about the sexual conduct of the patient by using different questions. The nurse modified questions to allude to sexual conduct in the last stage of talking. The nurse did not make conclusions about sexual conduct. The nurse probes about suicide by going round the topic. The nurse modified questions in the third stage of talking. Sometimes, the nurse has to reformulate the topic. The nurse might make conclusions about what really concerns the patient in order to make sure that the patient refrains from suicidal thought.

The application of Buddhist belief: In sexuality the nurse applied Buddhist belief to discourage the patient from spreading infection. Spreading infection might be used as a means for taking revenge, but this kind of revenge should be regarded as a sin. In addressing the issue of dread, the nurse applied Buddhist belief to view life and accept death as part of the cycle of life. Death is an absolutely truth; nobody can avoid death.

The use of body movement: In addressing sexuality, the nurse sometimes taps part of the patient's body, such as an arm or hand, to convey that the patient must stop spreading infection and think of social responsibility. In talking about death the nurse sometimes taps, touches, strokes and caresses parts of the patient's body, such as their arm, hand and shoulder or back in order to support and encourage the patient to live longer and to fight against the disease.

The exit from the topic: The nurse exits from the context of sexuality by using emphatic constructions. The ultimate objective is for social responsibility. The patient should not spread infection. The nurse exits from the context of death by using a positive construction. The nurse wishes to support and encourage the patient to fight against the disease. The ultimate objective of this is for the patients themselves and their family.

My third research question is how the nurse applied theoretical knowledge in counselling practice. Peräkylä (1995) stressed the importance of investigating how the counsellors apply their theoretical knowledge in counselling practice. My response to his statement is that I have done it in the

Thai counselling context. The belief in patient-centeredness was the main theoretical knowledge applied in HIV counselling. Thai HIV/AIDS counselling appeared to be an asymmetrical interaction. Patients took on a different role compared with that described in western theory. In theory, the counsellor should encourage the patient to talk about what concerns them. However, my data showed that the nurse overwhelmingly initiated the topics. In addition, the way in which patients took a passive role was visible in the turn design and turn size. Patients produced short answers, resulting in a small turn size. This sometimes made it difficult for the counsellor to probe further. The nurse always reserved her role as a questioner, with the patient as an answerer. However, certain patients might be more active if they held a different status from that common to the majority of other patients. In my data, one patient was a monk, so he was active in asking questions.

Nurses understand the sensitivity of talking about sexuality, and thus must address it indirectly. They exercised this knowledge by using an apologetic form to talk about sexuality. In addition, the nurses tapped parts of the patient's body to make them feel secure. Some nurses used hand movements to encourage patients. For example, the nurse stretched out a hand then retracted it quickly in order to encourage patients to fight against death. This kind of action made death appear weaker, or in this study I referred to this technique as death fakerealism. The nurses also used lexical choice in managing the sensitivity of certain topics; they produced supportive words such as 'must' or 'strong'. In order to make such words work efficiently, the nurses might stress those words, and sometimes they produced them louder. In a specific manner, those words were related to power because they were produced in imperative forms. The patient's turn showed that the patient agreed with what the nurse said. The patient produced an upgrading agreement that she had to wake up to fight against death. Importantly, the use of a Thai cultural gesture, the so called '*wai*', was visible. This action was used to initiate the topic of death. The nurse alluded to the topic of death by producing a pause. This reflected universally that the nurse could not apply her theoretical knowledge straight to the point, but it was used after the production of a pause. Sometimes, the nurses picked up on cultural aspects such as eating culture or participating in the funeral of another person to allude to what concerned the patients, such as discrimination or death.

In addition the nurse could maintain empathy as this is viewed as critical in counselling. The nurse used the technique of paraphrasing by using a different form of statement that maintained the same meaning.

Sometimes many themes were discussed in one session, and consequently the nurses applied their theoretical knowledge by summarising. This was conducted so that the nurses were reassured about what really concerned their patients. The way in which the nurse used summarising was constructed in the further turns. This technique was used in some cases where the topic of suicide was addressed such as in cases 36 and 41.

Some patients cried when they were aware that they were dying. Crying made their topic salient. The nurse applied a counselling technique in response by using pause and silence and letting the patient cry. Most patients were met with a response of supportive utterances and body movements from their counsellors. Counsellors produced tapping, touching, caressing patients and even giving patients face tissues in their responses. This shows the way in which the nurse applies theoretical knowledge into practice.

Although the nurse applies knowledge from HIV/AIDS training to counselling sessions, the public health role of the nurse also plays an important role in dealing with some aspects. For example, the nurse assesses and pursues scepticism. The nurse seems not to believe or trust what her patient told her about sexual conduct and condom use. The nurse manages this by modifying questions.

Having shown the scene of counselling in one particular setting where the data were collected, it illuminates what was going on based on what really happens in Thai counselling. In order to clarify how this counselling scene in Thailand is different and unique, it should be compared to that in other contexts. As stated in some literature, western and Thai cultures lead to different communication to some extent. In this area, Burnard (2005) worked on culture and communication in Thailand and made comparisons between western and Thai cultures as a way of illustrating some cultural differences. Burnard (2005, p.92-93) points out that culture plays an important role in expressing words and non-verbal communication such as the gesture of '*wai*' or the putting together of the palms at different heights of *wai*. This means that cultural differences leads to different conduct in counselling to some extent. Importantly, the gesture '*wai*', mentioned by Burnard, is also found in my data. It also makes Thai counselling

different from that in western culture. However, it is not only such gestures that make Thai counselling different, but also other cultural aspects.

An explicit comparison is made in this section in two ways. First, the structure of health care in HIV counselling is compared with that described in the literature. Second, some overarching differences between HIV counselling in my data and that in other works, more precisely Peräkylä and Silverman's work should be illustrated.

In the first aspect, the structure of health care in consultation as described in the literature is shown, along with the structure of health care in my data. Byrne and Long (1976) analysed more than 2000 consultations. They then identified the procedure or overall structure of primary care, consisting of six stages: opening, presenting complaint, examination, diagnosis, treatment and closing. This structure is based in primary care (see also Robinson, 2003). However, in counselling in Thailand, the structure of health care in the context of HIV counselling is different. While the overall structure of primary care is found in the manner of stages, the phases of health care in Thai HIV/AIDS counselling are different. Analysis of turn taking in consultation helps reveal that there are many key themes raised, and health care is one important theme in a session. The opening and closing of consultation are found universally. But the phases in between the opening and closing are different. In my data, the co-participants move on to other topics. It is like a checklist of topics. It is important to reiterate that counselling in Thailand is not restricted solely to health care, but is joined by different topical areas of the patient's life which cause the patient concern. Thus it can be said that HIV/AIDS counselling here is more than just health care counselling.

In addition, as a second comparison, I would like to show some different strands in my study compared to that in other contexts, such as the UK and USA. The main differences which should be underlined are the issue of guidelines determined by the WHO, the theoretical approach, the nurse-centredness, the aspect of privacy, death talk and religious support, the emotional aspect and the public health role. Each aspect is shown in the following sections.

First, I start by looking at the issue of guidelines determined by WHO. As shown in the previous chapter, nurses are trained in theoretical knowledge for counselling, as determined by WHO. Patient-centeredness is the main approach

taught to counsellors during the training courses. This means that the nurse, as counsellor, must encourage the patient to take the initiative talking. The nurses were educated in many aspects of theory. They were expected to follow those guidelines by applying them in their routine tasks. For example, the issue of empathy is regarded as important according to the theory. One counselling skill which counsellors should develop is empathizing with the patient (see WHO, 1994b, p. 28). In this area, empathy is encouraged over sympathy. WHO (ibid) states that '[e]mpathy is more than sympathy; it involves trying to place oneself in another's situation'. Counsellors as professionals should control their emotions (ibid). This skill is important so as to enable counsellors to promote the autonomy and problem-solving skills of the client, as recommended by WHO (ibid). This expectation was similarly found in the training courses for counselling examined during ethnographic field research in Thailand. When I participated in counselling training courses, participants were told to underline this skill of empathy. However, in real practice, the nurse applied this knowledge differently in her counselling task. Some nurses were displaying considerably more sympathy rather than empathy. The nurse applied particular gazes during a session, and she hugged the patient. In addition, ethnographic data indicates that the nurses support the patient financially. These things which the nurses are doing should be referred to other organisations or professional bodies. Referral is the next process which the counsellor has to go through when she finds out her task goes beyond counselling. Indeed, in the Thai HIV task, the support of the HIV patient network or social welfare is given to patients, but not all patients were supported by those financial sources. In some cases, the patient was not able to solve this kind of problem. It is thus frequently found that the nurse includes this kind of support in health consultation.

Apart from the sympathetic and empathic issue and financial support, the position in which the nurse sits in counselling is different to that recommended by WHO. The counsellor should sit comfortably, but in the manner of square sitting. This sitting position helps protect the counsellor from exposure to any germs or disease from the patient's respiratory system. However, in the Thai context, sometimes the nurse and patient sat so closely that they could touch one another, and they occasionally did not sit in a square position. In addition, according to WHO's guidelines, the nurse has to encourage the patient to talk.

This may seem relevant to western culture in the sense that people are more active and they openly express their concerns. Their communication style is direct. This is thus applied to use in the Thai context. However, Thai people are typically reserved and brought up to be calm, tolerant and modest. Their communication style is indirect and they may suppress negative emotions, as shown earlier. These thus affect the style of medical interaction. It makes the characteristics of health consultation in the Thai context different from that in western countries.

Second is the theoretical approach used in counselling. A particular theoretical approach may be applied to counselling in some areas. For example, the Milan School Family Systems Theory is applied in counselling in the work of Peräkylä. In Thai counselling, there is no specific theoretical approach developed according to the basis of a Thai background. An approach which could be applied in HIV/AIDS counselling in Thailand is a patient-centered one. Although patient-centeredness was supposed to be the core approach, it was not applied in counselling in my data. Nurse-centeredness was more dominant. This leads to another different aspect in the following issue-nurse-centeredness.

As stated earlier, the counselling in Thailand should be conducted primarily based on patient-centeredness. However, it is not completely patient-centered. As the data clearly show, the nurse is dominant in engaging in talk. The nurse typically introduces the topics which concern the patient. This is rather different from counselling in western cultures, where patient-centeredness has been applied to the counselling task since the post-war period, and it can be seen clearly. In other words, western patients reserve a more active role than Thai patients. In Thai counselling, the nurse-centered scene represents, to some extent, asymmetrical interaction between the nurse and patient. The term 'asymmetrical interaction' indicates the fact that the nurse is the person who frequently initiates the topic, and engages other participants in talking about it. In addition, the language used by the nurse can also indicate the status of the speaker. The nurse frequently uses the imperative form to forcefully recommend that the patient take some action.

Fourth is the aspect of privacy in a counselling session. Privacy plays an important role in Thai counselling and in the western context, but in different ways. It can be said that in theory HIV counselling is confidential talk, and how

the nurse maintains that confidentiality in my data must be mentioned here. In visiting patients' homes, the nurses conducted the counselling differently according to each setting. In the setting where a patient dwelt alone in her house, the nurse talked to the patient openly and they discussed the stages of infection and mentioned words like 'AIDS' freely, but this could not be done in another setting. Another two nurses visited a patient in the company of relatives and neighbours. The patient was not invited into a private room, but the way in which the nurses addressed the patient seemed to be another way for maintaining confidentiality. The nurses maintained it by avoiding mentioning anything obviously related to HIV and AIDS, even though most people realised what this patient was infected, and there were several people infected with HIV in that same village at that time.

Fifth, talk on the topics of death and religious support is quite central to my research data. The nurse mostly initiates the topic of the future indirectly, so as to prepare her patient to discuss death and dying. The term 'future' means the deterioration of the patient, and that causes the patient to confront the possibility of death in the future. The nurse discusses this so that she can be assured that the patient is well-prepared for the future. In talking about death and dying, the way in which the nurse looks at it and discusses it is different. According to Thai belief, and in some other Asian countries, life is not ours, and we cannot completely control life. Life depends on several factors. These beliefs are different from that in western cultures. Western people were brought up to be able to control their life, and they may conquer death. They should then attempt to delay death if they can. Buddhist Thai people were brought up to believe that death is part of the normal life cycle. This recommends that death be viewed as part of nature. People should not delay death because delaying death causes them suffering. They should accept it and deal with it calmly when it is imminent. Religious support has been applied in a session to make a patient accept a destiny and continue living. This has been brought in full into HIV/AIDS counselling. The Buddhist aspect then plays an important role in counselling. The religious aspect has been applied in most sessions where the dreaded issue was addressed. This application aims to support and prepare the patient emotionally, mentally and physically for his or her future. In addition, the discussion of suicide is also central in HIV/AIDS counselling in the Thai context. Suicide attempts are also

focused on in Thai counselling. According to Thai Buddhist belief, committing suicide is sin. Importantly, a successful suicide leaves a burden to successors, such as partners, parents or children. The nurse thus finds it necessary to probe some patients for whether the patient has any thoughts of suicide attempts. The nurse mostly applies indirect questions to keep the patient distant from committing suicide. The way in which the nurse probes for suicide attempts is rather practical. For example, in one typical case (no. 18), the discussion of suicide is not terminated in at first attempt. The nurse moves to another theme and she comes back to the topic of suicide another time. This was conducted in this manner in order to assure the nurse about the patient's decision.

Sixth, emotions are evident following the discussion of a particularly sensitive topic such as death and dying, as shown earlier. In Thai counselling, an emotion is both a topic and a feature of interaction. As a topic, the people talk about emotion. For example, the nurse asked the patient whether they are afraid. The illustration of emotion was found frequently. As a feature, it is found alongside some sensitive topics. In this area, the data clearly show that the patient expressed emotion by crying during the health consultation when he or she was made aware of dying. The patient expressed emotion through facial expression and bodily movement. The nurse sometimes responded to those emotions with bodily movement. She applied gaze, touching, hugging and tapping to the patient when she needed to support the patient and made the patient feel secure or less stressed. However, the nurse did so after she had categorised the patient. These actions indicate that emotion plays an important role in HIV/AIDS counselling in the Thai context. This scene supports what has been shown earlier in that non-verbal communication is important in Thai health consultation. The nurse has to observe and interpret emotion displayed by the patient in order to profoundly understand what concerned her patient. Here, it is important to show an example. In case, no. 41, the data on video clearly show the use of emotion by the patient, categorized as a widow, and the responsive body movements of the nurse. The nurse was drying tears on one of the patient's cheeks while the patient was crying. On the subject of non-verbal communication, it is believed that Thai patients always suppressed negative emotions, but they may express them in bodily movement. Thus medical staff were trained to observe or interpret serious issues using body movements. I should compare this aspect in my data to the

work of Peräkylä and Silverman. In their work, some participants requested an HIV test, but participants in my data were already diagnosed as HIV positive, and they were at different stages of infection. Thus, the status of participants in my research is different compared to the patients in their work. In other words, some participants in the work of Peräkylä and Silverman had come for HIV tests, consequently they did not show their emotions so clearly.

Seventh is the use of body movement. The nurse applies different gaze and gestures to different patients. For example, the nurse touches, taps or even embraces female patients. The nurse uses some specific gestures with female patients. For example, in case no. 41, the nurse stared the patient's face closely while the patient was crying. In addition, the nurse dried tear on the patient's cheek (see Appendix D). This seems to be clear in Thai counselling. The nurse also touches and taps a part of the body of male homosexual patients who identified themselves as feminine. But the nurse rarely touches male heterosexual patients. My findings on the use of body movement may provide the answer to Burnard and Naiyapatana (2004, p.174):

'At one point, I found myself wondering if Thai people would make excellent counsellors and psychologists, so keen appeared to be their attention to observation and eye contact!' (Burnard and Naiyapatana (2004, p.174).

Eighth is the issue of the public health role. My data clearly show that this aspect of the health care role is different. The nurse always made an attempt to find out how the patient was infected, and whether they may spread the infection. In addition, the nurse also needs to know whether the patient has safe sex. These represent the public health role. The nurse does not focus on one aspect in her public health role. In most sessions, the way in which the nurse asked the patient the necessary questions demonstrates the practicality in counselling. The nurse did not explore the patient's statement in the prior turn, but somehow blends individuals, public health and social welfare into the session. The nurse makes an attempt to find out whether her patient understands her messages. This forces the nurse to move around topics. The public health role plays an important role in cases no. 41 and no. 4, as partly stated earlier. In case no. 41, the nurse discussed health care, family and death with the patient. However, in case no. 4 she focused

on whether the patient had safe sex or not. The nurse wished the patient to adopt as many messages as possible. In case no.4, the nurse uses a voluntary technique for sexual talk. The patient revealed that he got involved with commercial sex work. When the topic of death was brought into the discussion, the nurse did not probe further about death, but instead she initiated the topic of antiretroviral drugs. It is possible that the nurse did not talk further about death or suicide because she may have wished to distract the patient with the prospect of living longer by raising the issue of antiretroviral drugs. This may explain why the topic of antiretroviral drugs was addressed abruptly. It is clear in the next turn that the patient would like to take the drugs. Soon after, the nurse moved onto the topic of sexuality. She made an attempt to find out how the patient became infected. The nurse probed further about a platonic relationship with a friend, referred to by the nurse. When the nurse was able to make sure that the relationship in question was not a sexual relationship, the nurse moved to the aspect of family and financial circumstances. This represents the public health role of the nurse in Thai HIV/AIDS counselling.

In summary, the nurses applied their theoretical knowledge through the use of language in the cultural context. Although the central feature of counselling was questions and answers, body movements were used in addition to words in order to pursue each topic. A successful consultation is achieved not only through the use of particular words or utterance, but also by the way in which those words and utterances were produced. Although HIV/AIDS counselling in Thailand in a particular medical setting reflected an asymmetrical interaction, it encouraged most patients enormously and in an efficient manner. Such medical interaction, to some extent, might dissuade some patients from committing suicide. In addition, we can see how the overall structure of Thai counselling interaction appeared in practice.

9.6 Practical implications

The practical implications of this study consist of two aspects: my study revealed communication pattern or formats and provided a description of empathy.

I wish to illustrate from my data the issue of communicative format. In dealing with a delicate and sensitive topic such as sexual conduct, the nurse may be trained to use a general question. If the nurse is not provided with information relevant to the sexual conduct of the patient, the nurse may be advised to use a specific question (see Chapter Seven). In addition, in dealing with the matter of death, dying and suicide, the nurse initiates the topic by applying a general address. Then she moves to a specific address. This scene enacts the communication on death and dying successfully. My study also illustrates the communicative pattern of talking about death and dying in the manner of stages.

Regarding the description of empathy, I was inspired by Silverman (1997). Counselling theory underlines the importance of empathy. My data showed that the nurse could maintain empathy by using paraphrasing in her turn. However the nurse also applied sympathy in counselling. If we prefer to follow the standard method of counselling, the use of empathy should be highlighted more in training.

9.7 Future directions

In HIV counselling in other parts of Thailand, the role of norms and culture will differ in each area. This study recommends that research be carried out in other parts of Thailand. My detached observation is that counselling in rural areas must be different from that in Bangkok. Patients in Bangkok will be more concerned with their confidentiality as they are more private. It may be useful to identify findings that are generalisable to HIV counselling nationwide and also to identify findings that are unique to each area. This basic information can then be used to create a realistic guideline or manual for conducting HIV counselling that could inform medical students and staff.

9.7.1 Other medical care aspects

There are many serious diseases found in Thailand. Thalassaemia and cancer should be at the forefront of research in which CA is applied. It can be applied practically to understand how communication between nurses and other medical

staff and patients who own experience appears. CA helps demonstrate what kind of discussion should be concerned and how nurses and other medical staff can manage interaction and the sensitivity of certain topics.

Thalassemia was mentioned by nurses during in-depth interviews, as one of the most important diseases amongst Thai people in the northern part of Thailand. Patients with this disease have to talk with medical staff, especially pregnant women who are carriers or whose husbands are carriers. The female patient is normally recommended to have an abortion because their child will normally have a short life span.

Cancer is also frequently found in Thai patients. When patients are told the bad news that they have cancer, some of them may not accept it. Thus, medical staff need to counsel patients. Importantly, some patients are incurable and they need counselling. Medical staff must prepare them to confront an uncertain future including imminent death.

Gallstones: Apart from HIV counselling, thalassemia and cancer, CA can also be applied to study social interaction in the context of gallstones. During the data collection, I had an opportunity to discuss this with some nurses. They all agreed that this method was useful in studying the patient's need and the nurse's advice through health consultation.

9.7.2 Other research contexts

Recommendations for applying CA to other research areas are addressed in this section.

Mass media and mass communication: As I have been involved with this field, CA is highly suited to research on mass communication and the medium of news items. CA can clarify how the mass media can reserve a neutral role through language. The use of questions plays an important role in political news. CA can also reveal the way in which the political news can be political (see Hutchby, 2006, p.134). In addition, CA can be used to study talk-in-interaction in large organisations where press conferences play an important role in publicity or building up an image through public relations. During each press conference, journalists and correspondents always reserve the role as questioners, and the

representatives of the organization should be answerers. Thus, these co-participants interact through the use of language. The answerers should have their own tactics in dealing with questions posed by journalists. In addition, broadcast talk and audience participation talk can be studied by CA. Thus it is apparent that CA is practical for mass media studies.

Sexual studies: Teaching sensitive topic such as the topic of sexuality in schools is discussed nationwide. CA can help uncover how students make sense of sexual issues, and how teachers should teach students some sensitive topics such as sexual practice or sexual conduct. In addition, crimes such as rape, sexual harassment, and child abuse are shown in media coverage as daily news. CA helps explore the courtroom interaction in rape trials, other sexual assaults and child abuse. Studies in courtroom interaction can reveal how the practice of such crimes is made possible.

Appendix A: Transcription conventions

The linguistic symbols used in the transcripts in this study are from the system of Gail Jefferson (1984a, p.ix-xvi), which was developed for conversational data analysis and presentation in general. The symbols presented here are those which were used in the presented excerpts and appendix D.

Symbol: [

Explanation: A single left hand square bracket is used to indicate that the utterances from two speakers are overlapping.

Instance: Nurse: nothing [at all
Patient: [((shaking head)) no
Nurse: relaxed (.) [relaxed]
Patient: [((shaking head)) no

Symbol:]

Explanation: A single right hand square bracket is used to indicate the point at which the utterances stop overlapping.

Instance:	Nurse:	anything happened (.) that already [happened]
	Patient:	[happened] (.) that already happened

Symbol: =

Explanation: The equals sign indicates that there was no gap between two lines of utterances.

Instance:

Nurse:	((touching the patient's leg)) are (you) feeling hurt=
Patient:	=no

Symbol: (2.6)

Explanation: The number in parentheses indicates the length of a period of silence in seconds. For example (2.6) is two and six tenths seconds.

Instance: Nurse: ((clearing throat)) ((turning to the patient))
today (2.6) today how long ((clasping hands
together)) have you been discharged from
hospital
Patient: ((looking up)) (2.8) a week

Symbol: (.)

Explanation: A dot enclosed in parentheses indicates a small pause in talk of no more than one-tenth of a second.

Instance: Husband: if I told them about haemorrhage (.) they would not detect right
Nurse 1: uh (.) uh

Symbol: -

Explanation: A dash at the end of a word indicates a cut-off.

Instance: Nurse: mean (you) whether can have children? (0.1)
you want to have a child
(0.1)
Patient: would like to-
Nurse: ((laughing)) ((stretching body)) ((moving backwards)) ((---tapping the patient's arm 3 times---))

Symbol: WORD

Explanation: Capital letters are used to mark utterances that are produced at a louder volume than the surrounding speech.

Instance: Nurse: ((moving body forwards)) uh >WHEN NEED IT HOW TO DO< ((touching arm)) (1.0) need sex ((moving hand))
Patient: do not know ((shaking head)) ((smiling))

Symbol: Under

Explanation: Underlining is used to indicate a speaker's emphasis.

Instance: Patient: right (.) gone ((showing an index finger))
ONLY ONCE (.) that time
Nurse: er: (.) after going (.) had (you) thought much ((stretching hand))

Symbol: .hhh

Explanation: A row of 'h's prefixed by a dot indicates an intake of breath: the more 'h's, the longer the intake of breath.

Instance: Nurse: apart from this (.) Jao said that
Patient: .hhh

Symbol: hhh

Explanation: A row of 'h's without a dot indicates exhalation: the more 'h' s, the longer the exhalation.

Instance: Nurse: ((looking at the patient's face)) (2.0) ((clicking a pen)) hhh (.) where did you sell?
 Patient: around (the name of the place)

Symbol: :::

Explanation: Colons indicates the prolongation of the sound immediately prior to their uses: the more colons, the longer the prolongation.

Instance: Nurse: oh::do not worry (.) in society
 Patient: ((sniffing))

Symbol: ()

Explanation: Empty parentheses are used when the transcriber cannot hear what was said.

Instance: Patient: novice said kidding ((putting palm of hand on another arm)) there was once ((moving flat palm of hand)) but used a condom (.) prevented
 Nurse: ()

Symbol: (word)

Explanation: Words in parentheses are used to indicate what was inferred by the transcriber when the actual words are uncertain.

Instance: Nurse: no problem at school ((counting)) in community (.) in family have (they) discriminated against haven't they?
 Patient: no

Symbol: ° °

Explanation: A degree sign is used to indicate that a passage of talk is quieter than surrounding sequences of talk.

Instance: Nurse: ((moving hands)) if one day you are not healthy to work
 Patient: (4.0)
 Patient: means °die°

Symbol: (())

Explanation: Double parentheses are used to describe actions instead of transcriptions.

Instance: Nurse: ((moving forwards)) ((caressing the patient's back)) (1.0) ((touching the patient's shoulder)) this thing can be sorted out (2.0) ((touching the patient's leg)) °one day (.) he might be lucky

Patient: that
((drying hand on pants))

Symbol: >>

Explanation: Two “greater than” signs are used to indicate a hurried start to an utterance.

Instance: Nurse: and (.) when did Nong >>start feeling this
 pain ((retracting hands))
 Patient: two days ago

Symbol: > <

Explanation: “More than” and “less than” signs are used to indicate that talk is produced at a quicker pace than the surrounding talk.

Instance: Nurse: (uh) ((tossing)) > how did you know they
 discriminate <
 Patient: brothers (.) sisters right ((nodding)) relatives
 blamed me

Symbol: ↑

Explanation: An upward pointing arrow indicates a marked shift of rising intonation. It is placed immediately before the onset of the shift.

Instance: Nurse: have not told ((shaking head)) him at all
 ↑right
 Patient: I did not tell him.

Symbol: ↓

Explanation: A downward pointing arrow indicates a marked shift of falling intonation. It is placed immediately before the onset of the shift.

Instance: Nurse: ((touching neck)) for this (.) it already
 happened (1.0) we start further new life (.)
 better ((tossing)) ↓right
 Patient: ((nodding)) right

Symbol: →

Explanation: Arrows pointing to the right are sometimes used to mark the area of the transcript which is the target of analysis.

Instance: Patient: do more publicity towards other
 → patients (.) AIDS is still related to
 → discrimination
 Nurse: ((looking straight))

Symbol: ((---tapping the patient's leg 6 times---))

Explanation: This symbol indicates that the speaker is continuously displaying the body language described in the double parentheses.

Instance: Nurse: not good ((touching the patient's arm))
 ((---tapping the patient's arm 9 times---))
 Patient: ((laughing)) ((sniffing))

Appendix B: Table of video consultation data

No	Type of recording	Counsellor	Date of recording	Duration (minutes)	Gender and other detail
01	Single	Health educator	20 January 2003	33:27	Female widow with one daughter
02	Single	Nurse	21 January 2003	49:38	Male, schizophrenic
03	Single	Nurse	21 January 2003	21:12	Female living with a new husband who is HIV negative
04	Single	Midwife	23 January 2003	15:00	Male, homosexual, identified himself as feminine, commercial sex worker
05	Single	Nurse & Midwife	23 January 2003	11:00	Male, schizophrenic, received counselling at home in the presence of some relatives. The patient passed away after the data collection
06	Single	Nurse	24 January 2003	22:02	Female, living with a new husband who is not HIV positive.
07	Couple	Nurse	24 January 2003	16:17	The couple's son was present for the recording and was waiting for a blood test.
08	Single	Psychologist	27 January 2003	35:17	Female, widow whose husband shot himself dead
09	Single	Nurse	27 January 2003	21:19	Female, widow with a daughter
10	Single	Nurse	14 February 2003	39:25	Male, a drug user
11	Couple	Nurse	14 February 2003	62:02	Husband was not HIV positive
12	Single	Nurse	19 February 2003	22:51	Female, widow
13	Single	Nurse	19 February 2003	25:30	Female, living with a husband who is not HIV positive. Previously had a successful abortion
14	Single	Midwife	20 February 2003	29:22	Female, widow,
15	Single	Midwife	20 February 2003	42:25	Female, widow
16	Single	Nurse	20 February 2003	56:30	Male, widower with a son, leader of HIV patients network
17	Single	Midwife	27 February 2003	57:23	Female, widow with children
18	Single	Midwife	27 February 2003	26:18	Unmarried man

19	Single	Nurse	27 February 2003	34:39	Female, widow with a daughter
20	Single	Nurse	27 February 2003	31:56	Female, widow
21	Single	Nurse	27 February 2003	21:18	Female, widow with children
22	Single	Nurse	28 February 2003	28:24	Female, widow with a son
23	Single	Health educator	28 February 2003	33:42	Female, widow with a son
24	Single	Nurse	28 February 2003	24:08	Female, widow with a son
25	Single	Health educator	4 March 2003	32:45	Male aged 50, homosexual, Identified himself as feminine commercial sex work
26	Single	Nurse	7 March 2003	44:02	Female, widow with a son
27	Single	Nurse	7 March 2003	47:00	Female aged 17, widow with a son
28	Kinship	Midwife	20 March 2003	55:52	Younger sister who had been infected with the virus before her elder brother.
29	Single	Nurse	20 March 2003	44:43	Female, widow with children
30	Single	Midwife	20 March 2003	46:44	Female, widow
31	Single	Nurse	20 March 2003	40:12	Female, widow
32	Company of a son	Psychologist	24 March 2003	21:30	Female, widow with a son living with HIV
33	Single	Nurse	26 March 2003	21:30	Female, living with a daughter and a new partner
34	Single	Nurse	26 March 2003	54:21	Female, widow with a daughter, leader of HIV patients network
35	Single	Nurse	27 March 2003	75:00	Male, monk
36	Single	Nurse	27 March 2003	46:03	Female, living with a son received counselling at home
37	Single	Midwife	10 April 2003	35:16	Laotian, male, remarried with a son
38	Single	Midwife	10 April 2003	42:14	Female, widow with children

39	Single	Midwife	10 April 2003	28:00	Female, widow with children
40	Single	Midwife	10 April 2003	26:47	Female, widow with children
41	Single	Midwife	15 May 2003	38:03	Female, widow with a daughter
42	Couple	Nurse	21 May 2003	35:21	Husband passed away after the data collection
43	Single	Midwife	22 May 2003	64:49	Male, homosexual, identified himself as feminine, commercial sex worker, subsequently passed away

Appendix C: Consent forms for nurses and patients

THE UNIVERSITY *of York*

DEPARTMENT OF SOCIOLOGY

A Sociological Study of Language in HIV/AIDS Counselling
between Nurses and Patients in Thailand

Consent form for patients

Name of person giving consent:.....

Name of researcher:

I have read the information sheet. I have had a chance to talk about it with the researcher. I have asked any questions I had, and I am happy with the answers.
yes / no

I agree that my consultation on treatment and care on.....(date) can be video taped. I understand that complete anonymity and confidentiality will be preserved at all time and that the video will be kept safely and used as outlined in the information sheet.
yes / no

I agree to talk with the researcher about my experience, and I agree to this discussion being recorded on audio tape.
yes / no

I understand that if I feel the matters discussed were too personal or too sensitive, I am free to ask for recording to cease, for the tape to be erased and to leave the study at any time without any risk, harm or detriment of my health care.
yes / no

I understand this study is intended to improve knowledge about AIDS counselling generally and I realize it may not benefit me personally.
yes / no

I consent to take part in this study.
yes / no
Signed:.....

Date:.....

I would like to hear about the results of the study
Address.....
.....
.....

If a family member or friend has come to the consultation, please fill in this section:
I consent to the consultation being video-taped.

Signed:..... Date:.....

For the researcher:
I confirm I have explained the study to the person or people named above.

Signed:..... Date:.....

เอกสารหลักฐานการเข้าร่วมโครงการวิจัยสำหรับผู้ป่วย

ชื่อ-สกุลผู้เข้าร่วมโครงการ.....

ชื่อ-สกุล ผู้วิจัย.....

ข้าพเจ้าได้อ่านเอกสารทั้งหมดและได้มีโอกาสพูดคุยในเรื่องที่เกี่ยวข้องกับโครงการวิจัยกับผู้วิจัยโดยตรง
เป็นอย่างดี ตลอดจนได้สอบถามในเรื่องที่ข้าพเจ้ามีความสงสัยและได้รับคำตอบและคำอธิบายจน
กระจ่างจากผู้วิจัยทุกประการแล้ว ใช่ / ไม่ใช่

ข้าพเจ้ายินยอมให้ผู้วิจัยบันทึกแถบภาพ (วิดีโอ) ในขณะที่ข้าพเจ้าคุยกับพยาบาลใน
วันที่.....(วัน-เดือน-ปี) ข้าพเจ้ามั่นใจว่าผู้วิจัยจะรักษาความลับตลอดเวลาใน
ระหว่างที่ข้าพเจ้าเข้าร่วมโครงการ และดูแลรักษาแถบภาพเป็นอย่างดีเพื่อใช้ประโยชน์สำหรับการศึกษา
และวิจัยตามรายละเอียดที่แจ้งไว้ในเอกสารการปกปิดและรักษาความลับในการทำวิจัย
ใช่ / ไม่ใช่

ข้าพเจ้ายินดีที่จะเล่าและพูดถึงประสบการณ์ของข้าพเจ้ากับผู้วิจัยและยินยอมให้มีการบันทึกแถบเสียง
ในระหว่างการพูดคุย
ใช่ / ไม่ใช่

ข้าพเจ้าเข้าใจดีว่าหากข้าพเจ้ารู้สึกว่าการที่ได้พูดคุยก่อให้เกิดความไม่สบายใจและกระทบกระเทือน
ต่อความรู้สึกของข้าพเจ้า ข้าพเจ้าสามารถแจ้งให้ผู้วิจัยยุติการบันทึกแถบภาพและลบในสิ่งที่ได้มีการ
บันทึกไปแล้วตลอดจนข้าพเจ้าสามารถขอยกเลิกการเข้าร่วมโครงการได้ตลอดเวลาโดยการยกเลิกไม่
ก่อให้เกิดผลเสียต่อการดูแลและรักษาโรคของข้าพเจ้าแต่อย่างใด ใช่ / ไม่ใช่

ข้าพเจ้าตระหนักดีว่าโครงการวิจัยนี้มีวัตถุประสงค์เพื่อพัฒนาความรู้เรื่องการให้คำปรึกษาในเรื่องโรค
เอดส์โดยรวมและอาจไม่เกิดผลหรือประโยชน์โดยตรงต่อข้าพเจ้าเป็นการส่วนตัว ใช่ / ไม่ใช่

ข้าพเจ้า ยินดี / ไม่ยินดี เข้าร่วมโครงการวิจัยนี้

ลงชื่อ..... วัน-เดือน-ปี.....

ข้าพเจ้าต้องการทราบผลการวิจัย และกรุณาส่งผลการวิจัยให้แก่ข้าพเจ้าตามที่อยู่
นี้.....

.....
.....
.....

ในกรณีที่ผู้ปวยมีญาติหรือเพื่อนติดตามมาในระหว่างการให้คำปรึกษา กรุณากรอรายละเอียดต่อไปนี้
ข้าพเจ้ายินดีที่จะให้มีการบันทึกแถบภาพในระหว่างการให้คำปรึกษา

ลงชื่อ.....วัน-เดือน-ปี.....

สำหรับผู้วิจัย

ข้าพเจ้าขอยืนยันว่าข้าพเจ้าได้อธิบายและแจ้งให้ผู้เข้าร่วมโครงการข้างต้นทราบถึงรายละเอียดที่
เกี่ยวข้องกับโครงการวิจัยทุกประการเป็นที่เรียบร้อยแล้ว

ลงชื่อ.....วัน-เดือน-ปี.....

THE UNIVERSITY *of York*

DEPARTMENT OF SOCIOLOGY

A Sociological Study of Language in HIV/AIDS Counselling between Nurses and Patients in Thailand

Consent form for health care professionals (nurses)

Name of person giving consent:.....

Name of researcher:

I have read the information sheet about the study and I have had a chance to talk about it with the researcher. I have asked any questions I had, and I am happy with the answers.

yes / no

I agree that my consultations with patients can be video taped.

yes / no

I agree to be interviewed about being an AIDS counsellor, and I agree to discussions being audio taped.

yes / no

I understand that complete anonymity and confidentiality will be preserved at all time and that the video and audio tapes will be kept safely and used as outlined in the information sheet.

yes / no

I understand that if I and my patients feel the matters discussed were too personal or too sensitive, I am free to ask for recording to cease, for the tape to be erased and to leave the study at any time without any risk, harm or detriment of health care of my patients.

yes / no

I understand this study is intended to improve knowledge about AIDS counselling generally and I realize it may not benefit me personally.

yes / no

I consent to take part in this study.

yes / no

Signed:.....

Date:.....

I would like to hear about the results of the study

Address.....:
.....
.....

For the researcher:

I confirm I have explained the study to the person or people named above.

Signed:..... Date:.....

โครงการวิจัยเรื่อง

การสื่อสารระหว่างพยาบาลและผู้ป่วยโรคเอดส์ : นัยที่มีต่อการดูแลสุขภาพผู้ป่วย

เอกสารหลักฐานการเข้าร่วมโครงการวิจัยสำหรับพยาบาล

ชื่อ-สกุลผู้เข้าร่วมโครงการ.....

ชื่อ-สกุล ผู้วิจัย.....

ข้าพเจ้าได้อ่านเอกสารทั้งหมดและได้มีโอกาสพูดคุยในเรื่องที่เกี่ยวข้องกับโครงการวิจัยกับผู้วิจัยโดยตรง
เป็นอย่างดี ตลอดจนได้สอบถามในเรื่องที่ข้าพเจ้ามีความสงสัยและได้รับคำตอบและคำอธิบายจน
กระจ่างจากผู้วิจัยทุกประการแล้ว ใช่ / ไม่ใช่

ข้าพเจ้ายินยอมให้ผู้วิจัยบันทึกแถบภาพ (วิดีโอ) ในขณะที่ข้าพเจ้าให้คำปรึกษาและพูดคุยกับผู้ป่วย
ใช่ / ไม่ใช่

ข้าพเจ้ายินดีที่จะให้สัมภาษณ์ในเรื่องเกี่ยวกับการเป็นผู้ให้คำปรึกษากับผู้วิจัยและยินยอมให้มีการ
บันทึกเสียงในระหว่างการสัมภาษณ์
ใช่ / ไม่ใช่

ข้าพเจ้าเข้าใจดีว่าหากข้าพเจ้าและผู้ป่วยของข้าพเจ้ารู้สึกว่เรื่องที่ได้พูดคุยก่อให้เกิดความไม่สบายใจ
และกระทบกระเทือนต่อความรู้สึก ข้าพเจ้าสามารถแจ้งให้ผู้วิจัยยุติการบันทึกแถบภาพและลบในสิ่งที่
ได้มีการบันทึกไปแล้ว ตลอดจนข้าพเจ้าสามารถขอยกเลิกการเข้าร่วมโครงการได้ตลอดเวลาโดยการ
ยกเลิกไม่ก่อให้เกิดผลเสียต่อการดูแลและรักษาผู้ป่วยของข้าพเจ้าแต่อย่างใด ใช่ / ไม่ใช่

ข้าพเจ้าตระหนักดีว่าโครงการวิจัยนี้มีวัตถุประสงค์เพื่อพัฒนาความรู้เรื่องการให้คำปรึกษาในเรื่องโรค
เอดส์โดยรวมและอาจไม่เกิดผลหรือประโยชน์โดยตรงต่อข้าพเจ้าเป็นการส่วนตัว ใช่ / ไม่ใช่
ข้าพเจ้า ยินดี / ไม่ยินดี เข้าร่วมโครงการวิจัยนี้

ลงชื่อ..... วัน-เดือนปี.....

ข้าพเจ้าต้องการทราบผลการวิจัย และกรุณาส่งผลการวิจัยให้แก่ข้าพเจ้าตามที่อยู่นี้

.....

.....

.....

สำหรับผู้วิจัย

ข้าพเจ้าขอยืนยันว่าข้าพเจ้าได้อธิบายและแจ้งให้ผู้เข้าร่วมโครงการข้างต้นทราบถึงรายละเอียดที่เกี่ยวข้องกับโครงการวิจัยทุกประการเป็นที่เรียบร้อยแล้ว

ลงชื่อ.....วัน-เดือน-ปี.....

Appendix D: Full CA transcript

The original counselling session was in Thai. It has been translated into English with full linguistic symbols. The symbols used in this transcript in are from the system of Gail Jefferson. Some have been replaced. For example pronouns used have been changed as appropriate for the sake of greater understanding for non-Thai native speakers.

Code:	Counselling Transcript–VDO–41
Date of recording:	15 th May 2003
Time:	13.25 hrs.
Setting:	Hospital
Participants:	A midwife and a female patient
Length:	38:03 minutes
Modified:	No

Background: The patient had been infected with HIV by her husband, who died several years ago. The patient now lives with her husband’s parents and she has a daughter. The patient was taking antiretrovirals and had experienced some side-effects from taking those drugs.

Synopsis: During the data collection, the patient came to see the counsellor because she was concerned about a particular symptom, and was afraid that she may have cancer. During the consultation, the patient did not seem to worry about her health. Consequently, the counsellor alluded to whether there was anything else that concerned the patient. The patient revealed that she also worried about her illness, the future of her daughter, and her property and expenditure. Regarding the future of her daughter, the patient worried that she would die soon, and would therefore be unable to look after her. In addition, she worried about her daughter’s education. In terms of property, she worries that her daughter would not be allocated a fair share of property. She would have liked

her husband's parents to give some property to her daughter. She worried that her husband's elder sister and brother-in-law might take over all of the property. In the patient's opinion, her husband's sister and brother-in-law were not honest. Thus, if her husband's parents could allocate the property in accordance with the eligibility of the patient's daughter, it would make the patient feel more secure and less worried. Last, the counsellor concluded that the patient worried about her daily expenditure because the patient was not very healthy and she could not earn enough money for herself and her daughter. However, the patient and her daughter were also supported by her husband's parents. During the consultation, the patient told the counsellor that her own father came to stay with her because he worried about her health and so he looked after the patient. Consequently, the patient's father was referred to in some sequences of talk. At the end of the sequences, the patient mentioned discrimination; she was discriminated against by her husband's sister and brother-in-law to some extent.

1. Nurse: ((clearing throat)) ((turning to the
2. patient)) today (2.6) today how
3. long ((clasping hands together))
4. have you been discharged from hospital
5. Patient: ((looking up)) (2.8) a week
6. Nurse: uh ((nodding)) a week
7. Patient: about a week
8. Nurse: and (.) when did Nong¹ >>start feeling this
9. pain ((retracting hands))
10. Patient: two days ago
11. Nurse: two days (1.0) having pain how feel pain
12. strongly ↑painful or
13. Patient: pain (.) pain like at lower::: stomach
14. Nurse: ((pressing the patient's stomach)
15. Patient: burped (1.0) sometimes (.) sometimes
16. (5.0)
17. Nurse: what are you worrying (.) what are
18. thinking
19. Patient: think ((looking down)) that at that time
20. (.) came to do ultra sound (0.1) stomach
21. (.) he (.) he
22. Nurse: ((retracting hand)) ((crossing arms))
23. Patient: did not tell anything said that nothing
24. Nurse: ((nodding)) uh
25. Patient: he said nothing he asked whether last
26. doctor told me what wrong (I) said (he)
27. TOLD (.)told me that lymphosis ((looking at

¹ *Nong* is a pronoun which refers to a younger person. When one addresses other people who are younger, he or she will be addressed as "*nong*". In this regard, the patient is younger than the counsellor. Consequently, the nurse addresses the patient by using the word "*nong*".

28. stomach)) then he did not say (he) kept
 29. silent
 30. Nurse: ((nodding)) (2.0) and you ((moving hand))
 31. ((shaking head)) did not ask at that
 32. time
 33. Patient: did not ask
 34. Nurse: and ((moving head)) why did not you ask
 35. that lymphosis >from where it happened<
 36. Patient: no sooner (I) started a question (.) than
 37. he kept silent
 38. Nurse: ((nodding)) ((tossing head)) last time when
 39. did ultra sound (.) where did
 40. (0.1)
 41. Patient: when came to stay ((tossing head)) at
 42. hospital
 43. Nurse: was it about a month?
 44. Patient: on the 13th
 45. Nurse: admitted (.) 13 APRIL ((touching the
 46. patient's leg))((smiling))
 47. Patient: ((smiling)) 13 April ((nodding))
 48. Nurse: was it right? err:: (0.2) when ((moving
 49. hand)) did ultra sound (.) what did the
 50. doctor (.) who did ultra sound (.)
 51. explain (.) found what found anything?
 52. ((showing hand))
 53. Patient: when admitted ((moving hand)) (.)
 54. he did not explain anything he said only
 55. got infected at urina [ry-
 56. Nurse: [urinary tract
 57. ((tossing head))((relaxing))
 58. Patient: urinary tract and (0.2) vagina
 59. Nurse: uh ((shaking head)) did not say anything
 60. else
 61. Patient: did not say anything
 62. Nurse: anything wrong did not know and you did
 63. not ask
 64. Patient: did not ask
 65. Nurse: any fatty tumor something you would not
 66. ((slightly shaking head)) dare to ask
 67. Patient: ((slightly shaking head)) did not ask
 68. Nurse: >INDEED (.) during treatment now (.)
 69. must talk (.) ((touching shoulder))<
 70. communication between a carer and patient
 71. ((stretching hand to patient))
 72. (.) patient has to ask if he told
 73. ((showing hand)) such as he said that
 74. there was lymphosis ((stretching
 75. hand)) the patient has to ask where
 76. lymphoma happened (.) which gland was it
 77. related to the stomach ache what I had (.)
 78. but what I guess ((moving forwards)) (0.2)
 79. ((clearing throat)) you are afraid (.) do
 80. not fear only lymphoma is it right
 81. Patient: (uh) ((nodding))
 82. Nurse: what do you fear (0.1) just say
 83. Patient: afraid of cancer ((smiling))
 84. Nurse: ((smiling)) (0.2) worry until now
 85. Patient: ((laughing))((raising shoulder up))

86. ((laughing))
87. Nurse: ((laughing))
88. Patient: ((laughing)) afraid of cancer (2.0)
89. .hhh only
90. Nurse: I will tell (.) how to tell (.) to make
91. happy that (.) we can find it ((nodding))
92. Patient: can be found ((nodding))
93. Nurse: amongst HIV patients (.) at one stage
94. (.) there have been symptoms of skin cancer
95. ((nodding)) or lymphoma
96. ((nodding))
97. Patient: ((nodding))
98. Nurse: but it is not often found (3.0) like (1.0)
99. Nongkran's case right
100. Patient: ((slightly tossing head))
101. Nurse: who lived at Ban Thar Ler (.) died (.)
102. found to be urethral cancer right (3.0)
103. ((moving forwards to patient)) ((touching
104. the patient's leg)) I mentioned this (.) I
105. don't mean (.) to make you [worry
106. Patient: [uh ((slightly
107. shaking head)) ((smiling))
108. (0.2)
109. Nurse: (you) are afraid of cancer (.)
110. afraid of only cancer or also fear death
111. Patient: ((slightly shaking head)) do not fear
112. death (.) afraid of cancer because I am
113. afraid of suffering (.) when got PAIN
114. Nurse: ((tossing head)) (0.1) you still feel
115. terribly painful
116. Patient: it (.) it happened sometimes
117. Nurse: ((nodding)) (0.1) uh
118. Patient: then it (.) disappeared
119. Nurse: symptoms ((stretching body)) for cancer
120. (.) it happens inside ((moving hand))
121. when getting pain (.) feel more and more
122. painful
123. Patient: ((slightly nodding))
124. Nurse: (.) strongly painful ((showing hand)) and
125. last long (.) then there is something else
126. ((counting)) constipation and diarrhea (.)
127. there ((counting)) might be mucus
128. Patient: ((slightly nodding))
129. Nurse: with blood (.) coming out from anus
130. Patient: ((slightly nodding))
131. Nurse: >here I don't want you to think ((nodding)<
132. Patient: ((nodding)) ((licking lip))
133. Nurse: that do not want (you) to think not because
134. that let (.) die when it is time
135. ((slightly shaking head)) not that
136. Patient: ((tossing head))
137. Nurse: but if (.) still keep thinking ((counting))
138. cancer and AIDS ((smiling)) has got (.)
139. one mutual thing when we are stressed
140. ((showing hand)) cells in our body (.)
141. tissues in our body will be abnormally
142. produced ((nodding)) if today we ((making
143. head-screw)) think ((slightly nodding)) we

144. get cancer (.) next day ((slightly
 145. nodding)) think again the day after
 146. tomorrow think again (.) if afraid of
 147. cancer ((putting hands together hand)) it's
 148. like we send our mind
 149. Patient: ((tossing head))
 150. Nurse: to that part to stimulate it (.) produce
 151. ((showing hand)) abnormal tissues
 152. Patient: ((slightly tossing head))
 153. Nurse: and it becomes as we think (2.0) like AIDS
 154. AIDS is the same whenever we worry much
 155. (.) or we worry that we do not have
 156. happiness (.) virus ((moving one hand
 157. round another)) has been increased more
 158. and more (.) that is why I ((touching the
 159. ptient's leg)) do not want you to worry BUT
 160. I ((nodding)) understand (1.0) that (.) it
 161. is ((moving forwards)) human nature right
 162. Patient: right
 163. Nurse: it happens ((nodding)) we have to worry (.)
 164. Patient: ((slightly nodding))
 165. Nurse: that (3.0) in particular it ((touching
 166. breast)) happens to ourselves (.) we
 167. definitely think
 168. Patient: think
 169. Nurse: uh
 170. Patient: but the doctor also checked cancer (.)
 171. he did not tell me (.) he checked cancer
 172. several times
 173. Nurse: cancer (.) where (.) that he checked
 174. Patient: uterus cervix
 175. Nurse: ((retracting hand)) >checking uterus
 176. cancer and cervix cancer ((nodding))(.)
 177. that is different<
 178. Patient: uh ((slightly nodding))
 179. Nurse: do not think that the doctor is cheating
 180. what I would like to tell is that ((putting
 181. hands together on a desk)) for cervix it is
 182. at the edge ((moving hand))
 183. Patient: ((nodding))
 184. Nurse: and uterus ((penetrating a finger in
 185. another hand)) uterus is inside
 186. Patient: ((nodding))if inside
 187. Nurse: do not know which part if would like to
 188. know (.) have to take that part to
 189. check (1.0) suppose we put equipment to
 190. ((showing two fingers)) get tissue a
 191. little piece (.) at early stage is it
 192. right
 193. Patient: ((nodding))
 194. Nurse: cannot get the right one (.) cannot find
 195. either ((showing two fingers)) there is
 196. two kinds of uterus cancer ((counting))
 197. first at the cervix where we take its
 198. tissues to check
 199. Patient: ((nodding))
 200. Nurse: second inside of uterus (.) this
 201. cannot take it to check >unless there is

202. symptom such as bleeding (.) abnormal<
 203. (0.1) take the tissue or cut some tissues
 204. to check (4.0)((smiling)) you ((touching
 205. the patient's leg)) do not think that the
 206. doctor told you a lie
 207. Patient: ((nodding)) (right)
 208. Nurse: uh (.) you already ((retracting hand))
 209. understood uterus cancer (1.0) then what
 210. are you thinking (1.0) think ((moving
 211. hand)) unhappy (.) worry are you thinking
 212. anything
 213. Patient: ((touching breast)) sometimes (.) not
 214. happy sometimes (.)DESPERATE my health
 215. was sometimes good:::
 216. Nurse: uh (.) have you thought that (.) was it
 217. related to antiretroviral drug use
 218. Patient: I think ((moving head)) something not (.)
 219. little (.)
 220. Nurse: (uh) ((tossing head))
 221. Patient: partially ((touching breast)) it may be
 222. Nurse: ((slightly tossing head))
 223. Patient: because ((touching breast)) my health is
 224. weak
 225. Nurse: last blood test was a good result
 226. ((nodding))
 227. Patient: ((pointing to herself)) tested (.) I
 228. thought on my own I considered I used to
 229. take these drugs ((touching nose)) I
 230. thought because of my own body
 231. Nurse: ((slightly tossing head))
 232. Patient: system
 233. Nurse: uh
 234. Patient: that
 235. Nurse: ((stretching body)) used to take ((moving
 236. forwards)) have been like this before
 237. Patient: no
 238. Nurse: what was (it)like last time
 239. Patient: felt dizzy
 240. Nurse: ((nodding))
 241. Patient: fever
 242. Nurse: ((nodding))
 243. Patient: vomited (.) pain at legs
 244. Nurse: um:
 245. Patient: but there was ((slightly shaking head))
 246. no such stomach ache
 247. Nurse: BUT during taking these drugs (.)
 248. you were not dizzy ((shaking head))
 249. nothing else
 250. Patient: ((shaking head)) no
 251. Nurse: took ((nodding)) these better ((moving
 252. hand)) than previous drugs
 253. Patient: nothing ((shaking head))
 254. Nurse: ((nodding))
 255. Patient: but there was stomach ache there was along
 256. body tired ((moving hand))
 257. Nurse: ((nodding))
 258. Patient: there was also fever ((moving hand))
 259. mix of many [symptoms

260. Nurse: [((touching the patient's leg))
 261. ((touching the patient's neck)) but todody
 262. there is no fever ((moving backwards))
 263. is it right?
 264. Patient: ((nodding))
 265. Nurse: ((tossing head)) (3.0) I saw your face I
 266. feel sympathetic on you (1.0) also worry
 267. about
 268. Patient: although being patient-
 269. Nurse: um:: ((nodding)) understand in mind (.) you
 270. still worry ((counting)) worry (.) then
 271. asked today (.) what still worry about (.)
 272. apart from >fear death (.) not fear
 273. death< afraid of being in pain (.) second
 274. one (.) afraid of it being cancer right (.)
 275. anything else (.) are (0.1) afraid of
 276. †future? ((retracting hand))
 277. Patient: also afraid
 278. Nurse: ((leaning a chair)) ((crossing arms))
 279. Patient: of future
 280. (4.0)
 281. Nurse: mean (.) your future or daughter's future
 282. Patient: future ((nodding)) of daughter
 283. Nurse: uh ((nodding)) what did talk to each other
 284. since (.) been ill
 285. Patient: talked ((nodding))
 286. Nurse: ((nodding)) ((nodding)) that
 287. Patient: already told that ((moving hand)) mum got
 288. this disease (.) mum already taken drugs
 289. and (2.0) mum ((putting upper lip on lower
 290. lip))((crying)) would ((wobbling voice))
 291. would ((pointing herself))
 292. Nurse: ((touching the patient's leg))
 293. Patient: ((sniffing)) recover
 294. or not mum did not know ((sniffing)) mum
 295. would get better mum did not know
 296. ((suppressing tears)) it took time
 297. ((suppressing tears)) right
 298. Nurse: ((slightly tossing head))
 299. Patient: but within few months mum could not tell
 300. you but taught her to do merits (1.0)
 301. concentrate on studying (1.0) there was a
 302. scholarship would get support .hhh be
 303. hard working (.) good people of society
 304. hhh do not get married (.) before getting
 305. married (.) have blood test first
 306. Nurse: um:
 307. Patient: look at mum's condition that told daughter
 308. Nurse: ((drying tears on patient's cheek))
 309. Patient: did not know whether mum ((sniffing))
 310. would get better after taking drugs or not
 311. (.) that told daughter ((suppressing
 312. tears))
 313. Nurse: ((nodding))
 314. Patient: she understood then nodded
 315. Nurse: uh
 316. Patient: already told daughter
 317. Nurse: ((nodding)) ((nodding)) what did daughter

318. say (.) ↑understood?
 319. Patient: understood
 320. Nurse: uh but ((shaking head)) did not say
 321. anything
 322. Patient: did not say
 323. Nurse: had daughter cried?
 324. Patient: cried ((nodding))
 325. Nurse: while talking to daughter (.) mum was
 326. crying like this? ((nodding))
 327. Patient: crying ((nodding))
 328. Nurse: ((stroking the patient's arm)) ((holding
 329. the patient's hand)) let (you) know one
 330. thing we will not leave each other
 331. Patient: ((nodding))
 332. Nurse: you can leave daughter with auntie Pii Ard
 333. ((look out)) our group all the time I do
 334. not want this thing to make you worry
 335. these worries make you disappointed
 336. Patient: ((nodding))
 337. Nurse: although this time Rajpracha scholarship
 338. is little
 339. Patient: ((nodding))
 340. Nurse: in the long run (.) (but) ((touching
 341. patient)) opportunity your daughter may
 342. get it again
 343. Patient: ((sniffing))
 344. Nurse: you have not thought about it Petch's son
 345. Patient: ((sniffing)) ((nodding))
 346. Nurse: (.) have seen Petch's son?
 347. Patient: ((nodding))
 348. Nurse: the other days (.) wife of governor would
 349. so if she could
 350. Patient: ((nodding))
 351. Nurse: but did not confirm but may have some for
 352. children 300 (.) 500 which we search for
 353. Patient: ((nodding))
 354. Nurse: may be not much but it can alleviate
 355. Patient: ((sniffing))
 356. Nurse: the burden
 357. Patient: I have thought this already if I she would
 358. be hard until nowadays I have got noone
 359. who helps
 360. Nurse: uh
 361. Patient: mum ((moving hand)) also nice but did not
 362. devote for us much
 363. Nurse: uh ((nodding)) ((nodding)) we understand
 364. Patient: we understand
 365. Nurse: because ((looking out)) her son no longer
 366. here that ((shaking head))
 367. Patient: ((nodding)) noone
 368. Nurse: was not alive
 369. Patient: ((nodding))
 370. Nurse: but her granddaughter she must love
 371. ((nodding))
 372. Patient: but niece she also loves
 373. Nurse: err:: but yourself (1.0))do not blame her
 374. for that (.) she does not love you (.) she
 375. is not kind to you but I think she is

376. ((nodding)) a good mother-in-law
 377. Patient: also ((nodding)) nice
 378. Nurse: right
 379. Patient: not bad
 380. Nurse: ((tossing head)) ((nodding)) >>this (.)
 381. worrying very much aren't you ↑right?
 382. Patient: ((sniffing)) worrying about (3.0) this
 383. afraid that she cannot survive
 384. ((sniffing)) afraid that she will wander
 385. along villages (.) afraid that (.) she
 386. does not behave
 387. Nurse: ((nodding))
 388. Patient: but she said that she would be wherever
 389. mum was
 390. Nurse: ((nodding))
 391. Patient: did not go anywhere
 392. Nurse: grand father ((shaking head)) has not come
 393. back yet?
 394. Patient: ((shaking head)) does not want to go back
 395. Nurse: um (.) um why (.) what did he say
 396. Patient: worrying (1.0) worrying about ((crying))
 397. daughter
 398. Nurse: ((nodding))
 399. Patient: his daughter was not still ((moving hand))
 400. healthy
 401. Nurse: ((tossing head))
 402. Patient: told like this ((sniffing))
 403. Nurse: ((tossing head)) err:
 404. Patient: if dad did not worry (.) dad would already
 405. go
 406. Nurse: ((nodding))
 407. Patient: if he had not had me ((sniffing))
 408. Nurse: ((tossing head))
 409. Patient: dad would have noone (1.0) he told
 410. Nurse: ((tossing head))
 411. Patient: others (.) he did not worry (.) worried
 412. only this sole daughter (2.0) does not go
 413. back ((suppressing tears)) will wait
 414. until daughter will be healthy
 415. Nurse: ((slightly nodding))
 416. Patient: but does not know when daughter will be
 417. healthy ((sniffing)) (1.0) when I had
 418. fever at night (1.0) it was him (.)
 419. looked after me (.) I think that nightly
 420. he kept thinking (.) he is old right
 421. Nurse: ((tossing head))
 422. Patient: but he did not say (.) he kept thinking
 423. ((sniffing)) ((sniffing))
 424. Nurse: who are living at Sukhothai?
 425. Patient: there (.) there (.) there::have got
 426. another two elder sisters (.) all have
 427. got married
 428. Nurse: ((nodding))
 429. Patient: ((touching nose)) also got an elder
 430. brother but he has got married
 431. Nurse: ((nodding))
 432. Patient: ((sniffing)) he did not come here (.)
 433. they sent him money

434. Nurse: uh ((nodding))
 435. Patient: ((sniffing)) ((touching nose))
 436. Nurse: and grand mother (.) no problem?
 437. Patient: ((sniffing)) no (.) they can stay together
 438. Nurse: uh ((nodding)) the centre
 439. Patient: ((sniffing))
 440. Nurse: for grand father and grand mother is you
 441. Patient: ((nodding)) you have to think like
 442. Patient: ((nodding))
 443. Nurse: is it right? (.) both worry about you
 444. Patient: ((nodding))
 445. Nurse: ((moving hand)) father and mother-in-law
 446. Patient: ((nodding))
 447. Nurse: and your own father (.) they care you
 448. Patient: ((nodding))
 449. Nurse: is that right? (1.0) I think so
 450. Patient: ((nodding))
 451. Nurse: of course there is also little bit of
 452. Patient: problem is it true?
 453. Patient: ((nodding))
 454. Nurse: but our community ((shaking head)) does
 455. Patient: not take that serious
 456. Patient: ((nodding))
 457. Nurse: but you have been lucky (.) lucky that
 458. Patient: you have met those nice people.
 459. Patient: ((nodding)) ((looking down)) I agree so
 460. Nurse: uh ((nodding)) (1.0) although their son
 461. Patient: died a long time ago
 462. Patient: ((slightly nodding)) several years
 463. Nurse: they do not still leave you behind
 464. Patient: I also talked with my neighbours
 465. Patient: ((nodding))
 466. Nurse: with neighbours (.) they said their
 467. Patient: son-in-law would come (.) did not know
 468. Nurse: what he would make more trouble (.)
 469. Patient: increased us a burden ((nodding)) but for
 470. Nurse: you your mother-in-law welcomes you (.)
 471. Patient: this means that you still have got merits
 472. Patient: ((sniffing))
 473. Nurse: right ((slightly shaking head)) then do
 474. Patient: not think of anything much
 475. Patient: ((nodding))
 476. Nurse: and (.) do not worry about it no matter
 477. Patient: what (.) partially I believe (.) it is
 478. Nurse: due to karma
 479. Patient: ((nodding))
 480. Nurse: right (.) part of it because we did it
 481. Patient: part of it we did it (.) for example
 482. Nurse: your case
 483. Patient: ((nodding))
 484. Nurse: your husband (.) partially you had chosen
 485. Patient: on your own
 486. Patient: ((nodding))
 487. Nurse: is it correct?
 488. Patient: ((sniffing)) correct
 489. Nurse: right (.) and part of it (.) you are ill
 490. Patient: like this probably is partially caused by
 491. Nurse: your previous karma (.) and another part

492. (.) your husband brought it that he did
 493. ((nodding)) it on his own and passed it on
 494. to you
 495. Patient: ((sniffing))
 496. Nurse: right
 497. Patient: right
 498. Nurse: like last time we used to listen to the
 499. monk whom I invited here preached that
 500. when we had these karmas we should
 501. entirely accept them but did not let life
 502. go down
 503. Patient: ((slightly nodding))
 504. Nurse: we accepted that this happens because of
 505. karma
 506. Patient: ((putting one lip on another))
 507. Nurse: that would make mind stronger in that (1.0)
 508. this is determined for us
 509. Patient: ((nodding))
 510. Nurse: we had to be patient had to fight against
 511. it willingly
 512. Patient: ((nodding))((sniffing))
 513. Nurse: do not be upset
 514. Patient: ((looking up)) I prayed ((moving hand))
 515. everyday (.) thought that I have been like
 516. this (.) due to my previous karma
 517. Nurse: ((nodding))
 518. Patient: I got infected with virus from husband
 519. then I become ill like this (.)
 520. encountered the thing I should not (.)
 521. but I did ((pointing herself))
 522. Nurse: ((nodding))
 523. Patient: I myself should not walk in this pathway
 524. Nurse: ((nodding))
 525. Patient: but why it pulled me along that way
 526. Nurse: ((nodding))
 527. Patient: I thought that it was due to ((moving
 528. lips)) my previous karma also
 529. Nurse: ((nodding)) (2.0) I would like you to be
 530. happy with this ((nodding))
 531. Patient: ((nodding))
 532. Nurse: no matter what if we accept ((nodding))
 533. Patient: ((slightly nodding))
 534. Nurse: it would ((stretching body)) ((smiling))
 535. our body ((touching breast)) we will
 536. perceive and ((tapping breast)) ourselves
 537. (.) do not need to struggle further
 538. finding answer ((touching patient))
 539. Patient: ((nodding))
 540. Nurse: if we accept this (.) then we do not need
 541. to find an answer (.) just keep going on
 542. living conducted by consciousness and
 543. happiness
 544. Patient: ((nodding))
 545. Nurse: do not want (.) to considerably worry
 546. Patient: sometime (.) staying at home (.) did not
 547. try to worry (.) but mum still kept
 548. repeating
 549. Nurse: what did she say?

550. Patient: sometimes she said (.) she would repeat
 551. the same thing.
 552. Nurse: such as
 553. Patient: suppose that (.) she said ((sweeping hand))
 554. many things about her family hhh sometimes
 555. I did not want to hear((moving hand))
 556. even my own matter I still feel worse
 557. Nurse: ((nodding))
 558. Patient: sometimes in the family they were not happy
 559. (.) there was a problem (.) dad has not
 560. come back yet (.) in family ((circulating
 561. hand)) about dad (.) dad and mum have not
 562. got divorced
 563. Nurse: uh
 564. Patient: they did not get on well with each other
 565. Nurse: ((nodding)) living in different houses
 566. Patient: living in different houses (1.0) dad
 567. Nurse: ((nodding)) has dad got a new wife?
 568. Patient: ((shaking head)) has not got (.) he would
 569. like to see daughter-in-law (.) he could
 570. not do
 571. Nurse: not getting on well with mum
 572. Patient: not getting on well with mum (.) mum
 573. obstructed the way did not let (him) get up
 574. to the house
 575. Nurse: you had to go down to see him instead
 576. Patient: I had to go down
 577. Nurse: saw dad
 578. Patient: saw dad
 579. Nurse: if went to see-
 580. Patient: to see (.) could not go to see he would
 581. do at night he would not dare to come (.)
 582. his wife was angry
 583. Nurse: uh ((tossing head)) but ((nodding))
 584. ((smiling)) you have known that
 585. father-in-law cares about ((nodding)) you
 586. Patient: ((nodding)) known but mother-in-law (.) to
 587. be honest (.) is rather antagonistic
 588. Nurse: ((nodding))
 589. Patient: last time I was admitted (.) in hospital
 590. she always said that (.) dad did not
 591. come to visit but indeed it was not like
 592. that
 593. Nurse: orr:: ((touching the patient's arm))
 594. ((tapping arm)) uh no it was not
 595. antagonising (.) she was afraid that (.)
 596. you would love dad more (.) afraid that
 597. would treat (.) dad was more important
 598. than her
 599. Patient: dad came right (.) she said that (.) dad
 600. did not often come (.) dad came
 601. Nurse: blamed ((laughing)) dad was so lazy
 602. Patient: so
 603. Nurse: not the same matter
 604. Patient: mum said >he did not come he did not visit
 605. at hospital< she would say like this
 606. Nurse: uh
 607. Patient: it was not (.) dad also visited

608. Nurse: and how about mum
 609. Patient: cut face
 610. Nurse: she was afraid would be not ((tossing
 611. head)) important
 612. Patient: currently (.) there are ((moving hand))
 613. many problems (.) she said (.) that's fine
 614. I came she would clear all the problems
 615. she said that what would be discussed
 616. would be done when [I am
 617. Nurse: [what's the problem?
 618. Patient: .hhh if would like to talk (.) let's talk
 619. ((moving hand)) when I am [still alive]
 620. Nurse: [ah ah ah let]
 621. tell problems ((moving forwards)) is it
 622. confidential?
 623. Patient: not really (.) not confidential they have
 624. not just happened I just want ((touching a
 625. desk)) it to belong to my daughter properly
 626. Nurse: ((nodding)) ((nodding))
 627. Patient: because (.) to be honest auntie and uncle
 628. are not quite honest people
 629. Nurse: uh
 630. Patient: I would like (.) grand dad (.) which one
 631. belongs to her dad (.) give it to niece
 632. Nurse: uh
 633. Patient: when I am still alive if he has not done
 634. it now and I have already gone my
 635. daughter is still young
 636. Nurse: ((slightly nodding))
 637. Patient: how can sort it out
 638. Nurse: ((nodding)) in case they have taken
 639. [all away
 640. Patient: [taken all away
 641. Nurse: and have you thought ((nodding)) the other
 642. way round that he has not yet given
 643. probably he was afraid that Paeng would not
 644. look after him=
 645. Patient: =no ((paralleling hands)) there is a part
 646. for her dad (.) not her own one
 647. Nurse: no (.) mean that ((putting two hands on a
 648. desk))how many sons (.) daughters have
 649. they got
 650. Patient: two ((raising two hands)) ((showing two
 651. fingers))
 652. Nurse: two (.) is that right ((counting)) there-
 653. Patient: uh
 654. Nurse: have
 655. Patient: ((counting)) there is her dad and sister
 656. of her dad (.)
 657. Nurse: ah ((wiping face))
 658. Patient: two
 659. Nurse: Paeng's dad is younger
 660. Patient: younger
 661. Nurse: err (.) here ((putting hands on the desk))
 662. there are three parts (.) can say three
 663. parts first belongs to his sister
 664. Patient: ((nodding)) uh
 665. Nurse: Paeng's dad another one is for parents

666. Patient: ((nodding)) uh
667. Nurse: then if they give their own to Paeng there
668. would be one left (.) but today they have
669. not given yet to Paeng because ((putting
670. arm on the desk)) ((shaking head)) today
671. they have not shared (.) they are not
672. sure whether you and daughter will stay
673. with them until they die ((raising hands))
674. possibly they may give their own whole to
675. Paeng ((wiping nose))
676. Patient: ((showing fingers)) this is not one but it
677. is three and they said that they would
678. divide it
679. Nurse: ((slightly nodding))
680. Patient: they said they would discuss soon (.)
681. dad implied that (.) his daughter forced
682. him
683. Nurse: um::(slightly nodding))
684. Patient: >will force him< ((pointing)) he worried
685. about ((sniffing)) ((crying)) this niece
686. ((tapping the desk))
687. Nurse understand ((nodding))
688. Patient: dad said ((wobbling voice)) (1.0) it was
689. right (.) but did not like his son who
690. died
691. Nurse: uh ((nodding))
692. Patient: his daughter but dad knew father-in-law
693. told the truth he said his daughter did
694. not love as much as his son
695. Nurse: ((nodding)) did not love him either
696. Patient: uh ((nodding))
697. Nurse: and he also loved his son very much
698. Patient: ((nodding)) ((sniffing))
699. Nurse: ((nodding)) ((nodding))
700. Patient: that's right he said that he would give as
701. he divides soon they would discuss
702. Nurse: ((nodding))
703. Patient: he said that his daughter would force him
704. (.) .hhh (1.0) force him
705. Nurse: then you have to talk
706. Patient: and he
707. Nurse: and do not worry you should talk to them
708. that you do not know how long you will
709. stay ((slightly nodding)) go ahead
710. talking if they will give it to Paeng
711. please divide then look for someone
712. trustworthy because Paeng is not mature
713. either
714. Patient: ((nodding))
715. Nurse: that would only say (.) that would give it
716. to Paeng
717. Patient: ((nodding)) that's right
718. Nurse: in the future (.) who will look after Paeng
719. Patient: that's right ((touching the desk)) I heard
720. (.) they came to talk at home (.) they
721. would force belong to them
722. Nurse: ((slightly nodding)) there are two homes
723. Patient: two homes

724. Nurse: two homes one belongs to dad
 725. Patient: ((nodding)) one belongs to dad
 726. Nurse: the other one belongs to mum
 727. Patient: ((nodding)) belongs to mum the other
 728. ((moving hand forwards)) one is mine
 729. Nurse: orr::
 730. Patient: one is mine ((writing on the desk))
 731. the other one belongs to dad
 732. Nurse: but ((nodding)) mum came to stay with
 733. Patient: mum ((nodding)) came to stay with
 734. Nurse: mum came to stay with [you]
 735. Patient: [farm] ((writing on
 736. the desk)) was divided into two (.)
 737. Nurse: ((nodding))
 738. Patient: two right (.) dad said on the other day (.)
 739. he would share it soon (.) then said
 740. ((looking down)) that did not let my own
 741. dad had gone back
 742. Nurse: ((tossing head)) uh (.) worry ((moving
 743. back)) ((shaking head)) should not worry (.)
 744. they are already ((nodding)) mature
 745. Patient: ((nodding))
 746. Nurse: do not be bothered (.) as I listened to it
 747. Patient: ((moving hand)) accidentally he spoke it
 748. out (.) made ((touching breast)) me not
 749. worry
 750. Nurse: um:: ((nodding)) (.) then ((smiling))
 751. what else makes worry
 752. Patient: now (.) not worry
 753. Nurse: ((nodding)) ((smiling)) saw you crying (.)
 754. feel bad
 755. Patient: ((scratching head)) indeed I rarely cried
 756. (.) if not necessary
 757. Nurse: look happy (.) do not have anything to
 758. worry about ((tapping the desk with a
 759. finger)) so regarding matter of concern
 760. (.) regarding nobody looking after Paeng
 761. ((counting)) cut it off ↑right
 762. Patient: ((nodding))
 763. Nurse ((counting)) a scholarship (.) cut it off
 764. because they will search for it (.) right
 765. ((counting)) (.) Rajpracha got it right
 766. funds that got it make use of it when
 767. have not money
 768. Patient: ((nodding))
 769. Nurse: talked to many people ((pointing out)) the
 770. other days that (1.0) governor's wife
 771. came before she left (.) she came to
 772. remind me that (.) please send it to me
 773. quickly
 774. Patient: ((nodding))
 775. Nurse: take to type it at home (.) will manage
 776. ((moving hand)) which one is pending
 777. Patient: ((nodding))
 778. Nurse: get it done first finished ((looking down))
 779. (1.0) one more thing is that (.) err::
 780. ((pointing to patient)) your matter (.)
 781. this is important issue (.) which must

782. concern (1.0) have thought
 783. Patient: ((licking lip)) ((touching nose))
 784. Nurse that become so due to antiretroviral drugs?
 785. (.) no
 786. Patient:. no (.) I think that just a bit caused
 787. by antiretroviral drugs
 788. Nurse: ((nodding)) (.) uh (1.0) nowadays have
 789. taken drugs everyday?
 790. Patient: ((nodding)) everyday
 791. Nurse: never ((shaking head)) stop
 792. Patient: never ((shaking head)) stop
 793. Nurse: ((nodding))
 794. Patient: any side effect from drugs (.) I have not
 795. seen
 796. Nurse: ((slightly nodding)) and now that been ill
 797. (.) stomach ache (.) can eat?
 798. Patient: ((nodding)) can eat
 799. Nurse: but ((tossing head)) not a lot
 800. Patient: not a lot (.) some days been good some
 801. days weary
 802. Nurse: uh ((leaning the chair)) ((crossing arms))
 803. Patient: ((clasping hands together)) some days dizzy
 804. Nurse: ((smiling))
 805. Patient: sometimes good:: mood (.) would smile all
 806. day long
 807. Nurse: ((nodding))
 808. Patient: if stressed
 809. Nurse: ((slightly nodding))
 810. Patient: started (.) getting stomachache
 811. Nurse: uh ((tossing head)) ((separating hands))
 812. knew that didn't you (.) ((moving hand))
 813. partially your illness came from (.)
 814. unsound mind ((raising hand))
 815. affecting your health
 816. Patient: ((nodding)) right
 817. Nurse: ((nodding)) uh (.) can notice that why do
 818. not make:: yourself in happy mood
 819. Patient: right (.) sometimes staying at home (.)
 820. looked that looked this now (.) since
 821. dad came here ((shaking head)) rarely felt
 822. much stressed
 823. Nurse: ((nodding)) uh
 824. Patient: previously (.) would be unhappy
 825. (.) dad came (.) ate (.) cooked and lying
 826. down (.) talking to dad
 827. Nurse: still cooking
 828. Patient: frankly ((nodding)) I had done alone (.)
 829. I was admitted discharged ((shaking head))
 830. mum did not do at all
 831. Nurse: she does not cook well or anything else
 832. she does not like cooking right?
 833. Patient: she did not ((shaking head)) cook (.)
 834. steamed glutinous² I did on my own
 835. ((tossing head)) cooked I tried::: being
 836. patient but I did not complain [anything]
 837. Nurse: [how about]

² Thai northern people normally eat glutinous. The way in which they cook it is by steaming.

838. Paeng (.)
 839. can Paeng steam glutinous
 840. Patient: also told her ((putting hand down)) that's
 841. her (1.0) could do one after another (.)
 842. had to force
 843. Nurse: ((tossing head))
 844. Patient: say a word (.) did not do previously told
 845. (.) said that (.) knew (.) knew (.) could
 846. do (.) but now single thing (.) one after
 847. another (.) single thing
 848. Nurse: ((tossing head))
 849. Patient: steamed glutinous only
 850. Nurse: uh
 851. Patient: other things (.) did not wake up
 852. Nurse: at least (.) teach
 853. Patient: ((wiping face))
 854. Nurse: to steam glutinous (.) cook ((nodding))
 855. Patient: ((sniffing))
 856. Nurse: if ((shaking head)) we do not teach (.)
 857. cannot do
 858. Patient: can cook (.) wash pots (.) clean home (.)
 859. wash alone
 860. Nurse: uh
 861. Patient: steam glutinous (.) if had not woke up yet
 862. it's me
 863. Nurse: ((nodding))
 864. Patient: right
 865. Nurse: uh (.) gradually
 866. Patient: for grand mum she does not understand
 867. Nurse: ((wiping forehead)) uh
 868. Patient: she does not understand the disease
 869. ((moving hand)) what I have been infected
 870. with when I was admitted in hospital I was
 871. still she still said that I got nothing
 872. ((touching breast)) ((nodding))
 873. Nurse: ((slightly nodding)) she said ((moving hand
 874. in and out)) at home that I got nothing
 875. not serious little bit but ((slightly
 876. moving head forwards)) she does not know
 877. the truth that my health was so weak:::
 878. Nurse: ((moving forwards)) ((stretching body))
 879. (1.0)
 880. Patient: she does not understand she thought that I
 881. was still healthy ((nodding))
 882. Nurse: did she care for you? ((nodding))
 883. Patient: ((slightly shaking head)) do not know I
 884. thought that sometimes ((putting hand on
 885. the desk)) she would ask how could that be
 886. I was ill I could go somewhere could so
 887. something indeed hard
 888. Nurse: ((nodding))
 889. Patient: I went to hospital she saw me gone
 890. somewhere she said (.) said that why I
 891. did not relax (.) how could sleep she
 892. said so (.) then she had gone (.) I had
 893. not money (.) it's her money she came (.)
 894. put money and gone like that
 895. (1.0)

896. Nurse: uh (.) now ((turning right))you have not
 897. got any income
 898. Patient: ((shaking head)) ((twitching a finger)) no
 899. Nurse: grand mum looked after
 900. Patient: grand mum also looked after ((twitching a
 901. finger)) but
 902. Nurse: ((touching face))
 903. Patient: sometimes could not eat
 904. Nurse: uh (.) it was not the same one you need it
 905. Patient: one I need
 906. Nurse: ((nodding)) uh I understand it (.) now you
 907. have not got any money at all
 908. Patient: got (.) some but not much
 909. Nurse: uh (.) ((nodding)) now how much tell me
 910. ((tossing head)) frankly
 911. Patient: now
 912. Nurse: ((smiling)) ((nodding))
 913. Patient: in this pocket
 914. Nurse: uh ((nodding))
 915. Patient: ((pointing out)) have got it (.) got only
 916. 200 (.) that dad gave
 917. Nurse: ((moving head)) in total have got only
 918. this?
 919. Patient: [in total?
 920. Nurse: [((pointing to the patient)) your own
 921. Patient: my own
 922. Nurse: uh
 923. Patient: have got ((showing two fingers)) 2,000
 924. Nurse: have got 2,000 ((tossing head)) save them
 925. Patient: ((tossing head))
 926. Nurse: ((nodding))
 927. Nurse: that's fine (.) still have got some
 928. Patient: have got some
 929. Nurse: right 2,000 (.) save it (.) earn from
 930. others
 931. Patient: I think like this ((nodding)) although
 932. they have got 100,000 (.) spend it all (.)
 933. my husband died did not leave anything
 934. Nurse: ((nodding))
 935. Patient: he had not got anything
 936. Nurse: uh (.) understand this
 937. Patient: BAAC³ (.) he had not either
 938. Nurse: ((nodding))
 939. Patient: so he did not leave anything
 940. Nurse: I can summarise as these (.) why you worry
 941. Patient: ((nodding))
 942. Nurse: I am not sure whether it is correct or not
 943. Patient: ((tossing head))
 944. Nurse: ((showing hand)) but as listened to
 945. ((counting)) first still worry regarding
 946. illness which you have got
 947. Patient: ((nodding))
 948. Nurse: the future of your daughter (0.1) right
 949. Patient: ((nodding))

³ BAAC stands for Bank for Agriculture and Agricultural Co-operatives of Thailand. Most patients in my data were agrarian. Most of them had obtained loans from this bank.

950. Nurse: about one which grand dad and grand mum
 951. will give and regarding money for
 952. expenditures is it right? (.) these four
 953. matters of concern
 954. Patient: uh
 955. Nurse: those are all big deals but regarding
 956. property can cut it off
 957. Patient: ((nodding)) because they have already
 958. promised that they would give (.) for
 959. money for expenditures (.) as I said we
 960. thought (.) although other people look
 961. happy they have got nothing to worry about
 962. ((showing hand)) they may have 100 (.) 200
 963. or they may not have at all even one bath
 964. Patient: ((nodding))
 965. Nurse: is it right?
 966. Patient: uh
 967. Nurse: you have got 2,000 (.) it can be spare one
 968. (.) but (.) a bit harder than others (.)
 969. because you still have got limitation (.)
 970. you are still ill you can not earn more
 971. Patient: cannot
 972. Nurse: right ((nodding)) regarding this (.)
 973. understood it (.) money is an important
 974. thing but (1.0) we will help each other
 975. (.) as we can right
 976. Patient: ((nodding))
 977. Nurse: if have got some money (.) will share you
 978. some
 979. Patient: ((nodding)) right
 980. Nurse: will share for Peang (.) not you
 981. ((smiling))
 982. Patient: I-
 983. Nurse: ((caressing arm)) give it for buying foods
 984. and for school
 985. Patient: normally I also ate but not much mostly
 986. my daughter ((nodding))
 987. Nurse: uh (.) but you have to explain her if
 988. ((putting two fingers on a desk)) normally
 989. give her 10 bahts have to decrease its
 990. amount (1.0) and whatever (.) unnecessarily
 991. (.) do not buy any (.) buy (.) eat ((moving
 992. one hand around another)) buy healthy foods
 993. (.) milk when (.) go out (.) I will talk to
 994. her again ((moving hand))
 995. Patient: ((nodding))
 996. Nurse: after she talked to me (.) is she better
 997. Patient: ((nodding)) better (.) the other days
 998. asked her (.) whether you understood what
 999. auntie Noi taught (.) she was crying (.)
 1000. crying while ((washing)) washing clothes
 1001. Nurse: ((laughing))
 1002. Patient: for a while (.) was getting better
 1003. Nurse: will encourage (.) naturally a young girl
 1004. normally loves parents
 1005. Patient: ((nodding))
 1006. Nurse: there is no other bad matters (.) unlike a
 1007. young boy (.) young boy (0.2) rather

1008. obstinate
 1009. Patient: obstinate
 1010. Nurse: do not worry about daughter I will help
 1011. regarding property discussed ((moving
 1012. hand))already (.) others cut them off
 1013. ((moving hand)) about illness (.) go as an
 1014. appointment right.
 1015. Patient: ((nodding))
 1016. Nurse: and drugs (.) do not stop no matter what
 1017. happens happen as we discussed first
 1018. ((caressing arm)) ((caressing arm)) please
 1019. think that it is your previous karma
 1020. Patient: ((nodding))
 1021. Nurse: it will be gradually getting better
 1022. ((touching breast)) today ((continuously
 1023. tapping breast 6 times)) make merits as
 1024. much as you can (.) only doing merits
 1025. ((pointing)) only having a good thought (.)
 1026. brings overwhelming positive outcomes
 1027. ((showing hand)) do not need to go to
 1028. temples (.) anywhere but if ((showing
 1029. hand)) have got some extra money share
 1030. little ((raising another hand up)) for
 1031. buying foods 10 or 20 bahts (.) >gave it
 1032. to Paeng (.) to bring to monks< that
 1033. ((touching breast)) makes your sound mind
 1034. ((moving hand)) most importantly (1.0)
 1035. make your mind happy (.) worship Buddha
 1036. statue (.) pray right
 1037. Patient: ((nodding))
 1038. Nurse: ((moving forwards)) ((touching the
 1039. patient's leg)) I do hope that when we meet
 1040. each other again next week must be
 1041. healthier than this both (1.0) physically
 1042. and mentally
 1043. Patient: right ((nodding)) ((smiling))
 1044. (1.0)
 1045. Nurse: the other days what I told (.) if I
 1046. supported you would fight against
 1047. ((nodding))
 1048. Patient: ((nodding)) fight against
 1049. Nurse: like this (2.0) uh right (.) we will fight
 1050. against (1.0) together right
 1051. Patient: ((nodding))
 1052. Nurse: but not only me ((moving hand)) [my team
 1053. Patient: [all in
 1054. team
 1055. Nurse: our team will support each other
 1056. Patient: to be honest ((crying)) that ((tapping a
 1057. chair)) since I have been here (.) nobody
 1058. leaves ((wobbly voice))[me ((crying))
 1059. Nurse: [that's it
 1060. Patient: ((moving hand)) I am ((wobbly voice))
 1061. really proud about this ((sniffing))
 1062. ((sniffing))
 1063. Nurse: I am also happy
 1064. Patient: ((showing hand)) although friends
 1065. ((blinking)) such as Roy is not healthy

1066. she still came ((touching breast)) to
 1067. visit me
 1068. Nurse: yes ((nodding))
 1069. Patient: because she realized that I was ill
 1070. Nurse: even Tom (.) you also know
 1071. Patient: ((sniffing)) right
 1072. Nurse: she came here
 1073. Patient: ((slightly nodding))
 1074. Nurse: Nobody ignores here (.) is it right?
 1075. lately since ((moving hand)) I have been
 1076. working here
 1077. Patient: I have thought no matter what I have been
 1078. I am proud
 1079. Nurse: uh ((nodding))
 1080. Patient: that I have doctors (.) look after (.)
 1081. never ignore ((sniffing)) counsellors also
 1082. never ignore (.) I am very happy with this
 1083. Nurse: ((touching patient)) ((nodding)) I have
 1084. also never ignored you
 1085. Patient: ((putting hand down))
 1086. Nurse: not only myself ((looking out)) like Pii
 1087. Ard (.) our team
 1088. Patient: ((nodding))
 1089. Nurse: never ignore each other right
 1090. Patient: uh
 1091. Nurse: right (.) have known
 1092. Patient: ((sniffing))
 1093. Nurse: why they did not ignore you? because you
 1094. are generous (.) other friends have been
 1095. ill you a black lady came ((smiling))
 1096. Patient: .hhh ((smiling))
 1097. Nurse: whether that black lady came
 1098. Patient: ((smiling))
 1099. Nurse: ((laughing)) this pii Ard would teasingly
 1100. talk to me like this >auntie Noi if this
 1101. black lady came here (.) she had to
 1102. accompany [someone<
 1103. Patient: [here I am also proud of this
 1104. ((nodding))
 1105. Nurse: this is a good outcome (.) this is a good
 1106. return which you have done it is it
 1107. right?
 1108. Patient: ((nodding)) right (.) but they blamed when
 1109. visiting patients because I have never
 1110. thought they are not patients because
 1111. they are like me ((touching breast)) right
 1112. Nurse: ((nodding)) ah
 1113. Patient: but I have always been careful to what
 1114. they have been
 1115. Nurse: yes ((nodding))
 1116. Patient: have to be careful because what I am I saw
 1117. others ill I would get close to them talk
 1118. to them
 1119. Nurse: ((nodding))
 1120. Patient: sometimes after talking they got better I
 1121. was also happy
 1122. Nurse: we are also happy ((touching the patient's
 1123. arm)) at least you are a consultant right

1124. Patient: ((nodding))
 1125. Nurse: that is why I asked you (.) lately you have
 1126. stayed with me you have become happier I
 1127. have known
 1128. Patient: good ((nodding))
 1129. Nurse: is it right?
 1130. Patient: happy
 1131. Nurse: happier since I have been here (.)
 1132. anything we help each other (.) no matter
 1133. what happens we never leave each other
 1134. behind do not worry about anything much
 1135. Patient: ((tossing head))
 1136. (1.0)
 1137. Nurse: tired? have been tired haven't you? (1.0)
 1138. tired?
 1139. Patient: also tired (.) a little bit tired
 1140. Nurse: err:: ((nodding)) relax?
 1141. Patient: ((tossing head))
 1142. Nurse: today ((touching patient)) you should be
 1143. much happier
 1144. Patient: ((nodding))
 1145. Nurse: all what we talked about (.) >when is the
 1146. appointment with the doctor?<
 1147. Patient: 12
 1148. Nurse: 12 June come as appointment ((moving hand))
 1149. if you don't have the money (.) nobody
 1150. accompanies here just ring me (1.0) I
 1151. will send someone to pick you up (2.0) do
 1152. not leave no matter what (.) whatever just
 1153. let know
 1154. Patient: if daughter goes to school dad will take
 1155. in charge
 1156. Nurse: does dad ride a motorcycle properly
 1157. Patient: father-in-law right
 1158. Nurse: ((nodding)) uh
 1159. Patient: can ride
 1160. Nurse: but not very well
 1161. Patient: ((nodding)) well
 1162. Nurse: uh
 1163. Patient: for their daughter (.) their son-in-law (.)
 1164. no (.) would tell the truth they were
 1165. afraid of being transmitted by me (.) to
 1166. be honest (.) son-in-law and daughter
 1167. Nurse: let them
 1168. Patient: afraid of transmission
 1169. Nurse: not easily get infected
 1170. Patient: ((suppressing tears))
 1171. Nurse: ((stretching body))((touching a patient))
 1172. as long as there are this type of people
 1173. (.) we have to know
 1174. Patient: ((sniffing))
 1175. Nurse: now in society (.) still have this kind of
 1176. of people [because
 1177. Patient: [because I also thought about it
 1178. ((putting hand on a desk)) even her brother
 1179. (.) she did not get close how come with her
 1180. sister-in-law
 1181. Nurse: ((smiling)) ah I have just known about it

1182. too like someone knew that (.) this house
 1183. had got AIDS patient ((sweeping hand))
 1184. they kept 100 metres distant from the
 1185. house
 1186. Patient: ((putting hand on a desk)) was admitted at
 1187. hospital (.) she rarely ((wiping a desk))
 1188. visited
 1189. Nurse: had brought foods anything?
 1190. Patient: uh ((shaking head)) rode a motorcycle
 1191. visited
 1192. Nurse: ((wiping face))
 1193. Patient: but her husband never visited
 1194. Nurse: it does not matter (.) they are outsiders
 1195. (.) outsiders ((touching breast)) who are
 1196. not you (.) not your daughter ((putting
 1197. hand on the desk)) not your own parents
 1198. they definitely love themselves
 1199. Patient: ((nodding))
 1200. Nurse: ((putting hand on a desk)) ((waving hand))
 1201. they do not need to love you
 1202. Patient: ((nodding))
 1203. Nurse: is that right?
 1204. Patient: ((nodding))
 1205. Nurse: ((waving hand)) ignore them
 1206. Patient: that's right
 1207. Nurse: make mind happy
 1208. Patient: I do not care (.) notice that a niece
 1209. sometimes a niece kept away
 1210. Nurse: ((nodding)) it doesn't matter (.) anyway
 1211. tell your dad as we talked
 1212. Patient: ((nodding))
 1213. Nurse: tell Dad
 1214. Patient: ((nodding))
 1215. Nurse: ((touching patient)) make mind happy
 1216. Patient: ((nodding))
 1217. Nurse: and do not forget to come as an appointment
 1218. (.) take care of yourself (.) Buddha
 1219. protects right
 1220. Patient: ((nodding))
 1221. Nurse: pray (.) if ((showing hand)) have got some
 1222. extra money
 1223. Patient: ((nodding))
 1224. Nurse: go to make donation ((putting hand on a
 1225. desk)) for the sake of ((tapping breast))
 1226. happy mind ((caressing arm)) ((smiling))
 1227. I will not disturb you more
 1228. Patient: ((smiling)) right
 1229. Nurse: your face is not that (.) look weary
 1230. Patient: ((nodding))
 1231. Nurse: will tell Paeng to do motorcycling home
 1232. ((looking outside)) ((moving forwards))
 1233. afraid (.) going to be rainy (.) start
 1234. being dark ((touching patient)) thank you
 1235. very much for coming today although I rang
 1236. you for general you came
 1237. Patient: want to come even if could not wake up
 1238. would like to come
 1239. Nurse: >IF ((shaking head)) COULD NOT wake up<

1240. Patient: ((touching nose))
 1241. Nurse: >ring me I would go to see you instead<
 1242. Patient: ((smiling)) .hhh
 1243. Nurse: do not come on your own
 1244. Patient: because you rang me right (.) told daughter
 1245. for phone
 1246. Nurse: that was auntie Noi
 1247. Patient: uh (.) took tablets (.) relaxed (.) happy
 1248. Nurse: ((nodding)) been happy already (.) can go
 1249. to do cycling right
 1250. Patient: ((nodding))
 1251. Nurse: ((touching patient)) will not disturb you
 1252. Patient: ((nodding))
 1253. Nurse: thank you very much (.) enough (.) that's
 1254. it
 1255. Patient: ((nodding))
 1256. Nurse: then we see again next Thursday 5th see
 1257. again I am afraid that I will not be here
 1258. next Thursday ((showing hand)) Thursday
 1259. 5th after next Thursday right (.) see again
 1260. ((nodding))
 1261. Patient: ((wai))⁴ thank you
 1262. Nurse: right ((wai)) ((touching the patient's
 1263. shoulder)) be healthier (.) when come next
 1264. time ((stopping audio recorder)) ((putting
 1265. a clipping microphone on the desk)) put
 1266. on more weight than this (.) really

⁴ *Wai* (ໄວ້) is an action for greeting by putting two palms of hand together. Normally, the younger people always perform this action for paying the respect the elder people first, and then the same action will be conducted by the elders in response to the respect offered by the younger.

Appendix E: Criteria for ARVs access and participation

Application form for participating in the National Access to Antiretroviral Program for People Living with HIV/AIDS

Background

The ministry of public health in co-operation with(name of hospital) has launched a programme called the National Access to Antiretroviral Programme for People living with HIV/AIDS. The objective of the programme is to provide HIV patients with an opportunity to receive treatment with ARVs in the form of 3 courses of drug therapy which will improve the patient's health and overall condition while decreasing opportunistic diseases and the risk of death.

Right of participant

1. The decision to participate in this programme depends only on you.
2. The decision not to participate in this programme does not affect any further treatment decisions both now and in the future.
3. You can terminate your participation at any time. You will still receive other routine treatment from this hospital.
4. You will be informed by the programme runner of any changes to the detail of this programme which may affect your co-operation or participation in this programme, so that you will be clear about those changes and can reconsider your decision to continue with the programme.

Duty of participant

1. To take ARVs regularly as recommended by the programme runner and to come to appointments punctually for treatment.

2. To inform doctors or the programme runner if you have made the decision to start another course of medicine or another treatment while participating in this programme.
3. To inform doctors or the programme runner if you have any symptoms while you are in this programme, even if they may be not from the use of ARVs or other treatment under this programme.
4. The decision to terminate treatment with ARVs under this programme should be agreed with the doctors or the programme runner beforehand.

Procedure

1. You will be asked about your treatment history, and undergo health checks, blood tests and a lung x-ray in order to determine whether you qualify for participation in the programme.
2. Having been considered eligible by the programme runner, you will be contacted to collect ARVs. Your ARVs are GPO-Vir. In the first two weeks, you will be given one GPO-Vir for morning and one lamivudine (3TC) with one stavudine (d4T) in the evening (twelve hours after the morning dose). After the first two weeks your course of ARVs will be adjusted to one GOP-Vir every twelve hours, or you will be given other courses of ARVs as the doctors or the programme runner see fit.
3. You have to come for follow up treatment at an appointment with a doctor. Doctors will make an appointment with you when you have finished taking ARVs at week 2, 4, 8 and every month until the end of the programme.

This part for hospital

4. Every time you come to an appointment for treatment, you will be asked your treatment history and undergo health checks and/ or blood tests for following up the disease and assessing the results of treatment, including the safety.
5. You will have a CD4 count twice a year.

Benefits from participating in the programme

You will receive free treatment with ARVs without paying any charges while you continue to participate in the programme, and free CD4 counts twice a year.

Expenses emerging after participating in this programme will be included in this programme. Participants will be responsible for other unrelated expenses. In addition, participants will obtain up to date information in terms of infection and disease status from care teams.

Side effects of ARVs

There are a number of common side effects caused by the drugs provided in this programme, for example rash might be found 16 % from taking navirapine (NVP). This is one of the drugs in GPO-Vir. In addition, around 10% may experience pneumonia from taking neviraphine. These side effects are less frequent with lamivudine (3TC) and stavudine (d4T). Around 2-3% may experience peripheral neuropathy from taking stavudine (d4T).

Confidentiality

The programme runner will keep patient history confidential. It will only be used for data analysis. Throughout the procedure of analysis, any documentation, including academic reports will not refer to a real name with anybody outside the programme.

This part for patient

Termination of treatment and participation in the programme

You might be told to terminate or leave this programme for the following reasons:

- 1. Doctors consider that the use of these drugs might have a detrimental, rather than beneficial, effect on your health.
- 2. You have not come for treatment at the appointed time and/or stopped taking drugs for a period longer than 7 days without first obtaining permission from doctors and the programme runner.
- 3. The doctors and the programme runner believe you are not taking the drugs in a regular manner.
- 4. You experience other severe symptoms while taking these drugs.
- 5. There is a treatment failure after the courses of drugs have already been changed.

If you have any further inquiries about this programme, you can contact
Programme co-ordinator (name).....
Address of hospital.....
Telephone number.....

This part for patient

I have read the information sheet and I understand the objective, procedures, rights and duty, as well as the potential benefits and disadvantages which result from participating in this programme. I have made the decision by myself and under my own right to participate in this programme. I understand that I can leave the programme at any time. In doing this, any current or further treatment from this hospital will be unaffected.

.....
Name of applicant	Signature/Name	Date/Month/Year
.....
Witness	Signature/Name	Date/Month/Year
.....
Witness	Signature/Name	Date/Month/Year

I, as a programme coordinator/programme runner have clarified the objective of the programme and its procedures to the applicant meticulously and consider that the above applicant understood fully and is willing to co-operate.

.....
Name of programme	Signature/Name	Date/Month/Year
Coordinator/programme		
runner		

Note: After the patient has signed this form, the patient keeps one copy and the hospital keeps another.

This part for patient

ใบสมัครเพื่อเข้าร่วมโครงการการเข้าถึงบริการยาต้านไวรัสเอดส์ระดับชาติ สำหรับผู้ติดเชื้อและผู้ป่วยเอดส์

ความเป็นมา

กระทรวงสาธารณสุขร่วมกับโรงพยาบาล.....ดำเนินโครงการการเข้าถึงบริการยาต้านไวรัสเอดส์ระดับชาติสำหรับผู้ติดเชื้อและผู้ป่วยเอดส์ ซึ่งโครงการนี้มีวัตถุประสงค์เพื่ออำนวยความสะดวกให้แก่ผู้ติดเชื้อเอชไอวีได้มีโอกาสได้รับการรักษาด้วยยาต้านไวรัสเอดส์ในสูตรแบบสามชนิดพร้อมกัน ซึ่งจะช่วยให้สุขภาพและคุณภาพชีวิตดีขึ้น ลดอัตราการเกิดโรคแทรกซ้อน และอัตราตาย

สิทธิของผู้เข้าร่วมโครงการ

1. การตัดสินใจว่าจะร่วมโครงการนี้หรือไม่ เป็นสิทธิของท่านโดยชอบธรรม
2. การไม่เข้าร่วมโครงการนี้ ก็จะไม่ทำให้ท่านเสียสิทธิในการได้รับการรักษาทั้งในปัจจุบันและอนาคต
3. การขอถอนตัวขณะที่อยู่ในโครงการ ท่านอาจจะขอถอนตัวเมื่อใดก็ได้ ทั้งนี้ขึ้นอยู่กับเหตุผลอันสมควร โดยที่ท่านจะได้รับการรักษาอื่นๆ ตามปกติเท่าที่เป็นไปได้ของสถานพยาบาลแห่งนี้
4. การเปลี่ยนแปลงใดๆ ในรายละเอียดของโครงการนี้ในอนาคต ซึ่งจะมีผลต่อการตัดสินใจในการร่วมมือ หรือคงอยู่ในโครงการนี้ของท่าน ผู้ดำเนินโครงการจะแจ้งให้ท่านทราบ เพื่อให้ท่านศึกษารายละเอียดที่เปลี่ยนแปลงไป และตัดสินใจใหม่อีกครั้งหนึ่งว่าจะร่วมโครงการต่อ หรือถอนตัวจากโครงการ

หน้าที่ของผู้เข้าร่วมโครงการ

1. การรับประทานยาอย่างสม่ำเสมอตามที่ได้รับคำแนะนำจากผู้ดำเนินโครงการและมารับการตรวจรักษาตามนัดอย่างเคร่งครัด
2. การแจ้งให้แพทย์ หรือผู้ดำเนินโครงการทราบหากท่านตัดสินใจที่จะเริ่มให้ยา หรือการรักษาอื่นขณะที่ร่วมอยู่ในโครงการนี้
3. การแจ้งให้แพทย์ หรือผู้ดำเนินโครงการทราบ หากท่านมีอาการผิดปกติใดๆ ระหว่างที่อยู่ในโครงการนี้ แม้ว่าอาการเหล่านั้นจะดูเหมือนไม่เกี่ยวกับยา หรือการรักษาในโครงการแต่อย่างใด
4. การหยุดการรับประทานยาในโครงการ ควรได้รับการร่วมตัดสินใจจากแพทย์หรือผู้ดำเนินโครงการก่อน

กระบวนการการดำเนินโครงการ

1. ท่านจะได้รับการซักประวัติ ตรวจร่างกาย ตรวจเลือด และถ่ายภาพเอกซเรย์ปอดจากแพทย์ และผู้ดำเนินโครงการเพื่อประกอบการพิจารณาว่าท่านจะมีคุณสมบัติเข้าข่ายที่จะเข้าร่วมโครงการหรือไม่
2. เมื่อผู้ดำเนินโครงการ พิจารณาว่าท่านมีคุณสมบัติเข้าข่ายที่จะเข้าร่วมโครงการ ท่านจะได้รับการติดต่อให้เข้ามารับยา ยาที่ท่านจะได้รับคือ จีพีโอวีเออร์ (GPO-VIR) โดยใน 2 สัปดาห์แรกท่านจะได้รับ จีพีโอวีเออร์ 1 เม็ด ในตอนเช้า และยาลามิเวดิน (3TC) 1 เม็ด ร่วมกับยาสตาวูดีน (d4T) 1 เม็ด ตอนเย็นห่างกัน 12 ชั่วโมง หลังจาก 2 อาทิตย์แรกแล้ว จะปรับขนาดยาเป็น จีพีโอวีเออร์ 1 เม็ดทุก 12 ชั่วโมง หรือได้รับยาต้านไวรัสสูตรอื่นๆ ที่แพทย์และผู้ดำเนินโครงการเห็นว่าเหมาะสม
3. ท่านจะต้องมารับการตรวจเพื่อประเมินผลการรักษาตามที่แพทย์นัดหมายทุกครั้ง โดยแพทย์จะนัดหมายเมื่อรับประทานยาครบอาทิตย์ ที่ 2, 4, 8 และทุก 1 เดือน จนถึงสิ้นสุดโครงการ

4. ทุกครั้งที่มารับการตรวจตามนัด ท่านจะได้รับการซักประวัติและตรวจร่างกาย และ/หรือ ตรวจเลือด เพื่อประเมินความเป็นไปของโรคและผลของการรักษา รวมทั้งความปลอดภัยของยาด้วย
5. ท่านจะได้รับการตรวจจำนวนเม็ดเลือดขาวชนิดซีดี 4 (CD4) ปีละ 2 ครั้ง

ประโยชน์ที่ผู้เข้าร่วมโครงการจะได้รับ

ได้รับการดูแลรักษาด้วยยาต้านไวรัสเอดส์ โดยไม่ต้องเสียค่าใช้จ่ายถ้าไม่มีข้อบ่งชี้ของการสิ้นสุดการรักษาและได้รับการตรวจเม็ดเลือดขาวชนิดซีดี 4 (CD4) ปีละ 2 ครั้ง โดยที่ค่าใช้จ่ายสำหรับการตรวจหลังจากเข้าร่วมโครงการแล้ว จะเบิกจากโครงการ ส่วนค่าใช้จ่ายนอกเหนือจากนี้ผู้เข้าร่วมโครงการเป็นผู้ร่วมรับผิดชอบ นอกจากนี้ผู้เข้าร่วมโครงการจะได้รับข้อมูล ความรู้เกี่ยวกับภาวะการติดเชื้อเอชไอวี อย่างต่อเนื่อง จากทีมผู้รักษา

อาการข้างเคียงจากยาต้านไวรัส

ผลข้างเคียงของยาที่ใช้ในโครงการที่พบได้ คือ ผื่นแพ้ยา ซึ่งอาจพบได้ 16% จากการกินยาเนวิราพีน (NVP) ซึ่งเป็นยาองค์ประกอบหนึ่งในยา GPO-VIR นอกจากนั้นยังอาจพบภาวะตับอักเสบจากยาเนวิราพีนได้ 10% ส่วนยาลามิวูดีน (3TC) และสตาวูดีน (d4T) ไม่ค่อยพบผลข้างเคียงมากนัก อาจจะมีภาวะเส้นประสาทส่วนปลายอักเสบได้ประมาณ 2-3% จากยาสตาวูดีน (d4T)

การปกปิดความลับของผู้ป่วย

ผู้รับผิดชอบโครงการจะเก็บข้อมูลส่วนตัวของท่านเป็นความลับและนำมาใช้เฉพาะในการวิเคราะห์ผลเท่านั้น ขั้นตอนการวิเคราะห์ผลการเก็บบันทึกต่างๆ ในแฟ้มโครงการ ตลอดจนการรายงานผลทางวิชาการ จะไม่มีการอ้างอิงถึง หรือเปิดเผยชื่อจริงกับผู้ที่ไม่มีส่วนเกี่ยวข้องอย่างเด็ดขาด

การหยุดการรักษาและการสิ้นสุดโครงการ

ท่านอาจจำเป็นต้องหยุดการรักษาหรือออกจากโครงการ แม้ท่านจะไม่เห็นชอบ หากเกิดสิ่งใดสิ่งหนึ่งดังต่อไปนี้

1. แพทย์ผู้ดูแลท่านเห็นว่า การใช้ยาต่อไปอาจมีผลข้างเคียงอันตรายต่อท่านมากกว่าประโยชน์ที่จะได้รับ
2. ท่านไม่มารับการตรวจรักษาตามนัดและ/หรือขาดยาเกิน 7 วัน โดยไม่ได้รับความเห็นชอบจากแพทย์และผู้ดำเนินโครงการ
3. ท่านรับประทานยาไม่สม่ำเสมอโดยการประเมินจากแพทย์และผู้ดำเนินโครงการ
4. ท่านเกิดอาการแทรกซ้อนอย่างรุนแรงระหว่างได้ยา
5. การรักษาล้มเหลวแม้จะได้มีการเปลี่ยนสูตรยาแล้ว

หากท่านมีคำถามเพิ่มเติมเกี่ยวกับโครงการนี้ ท่านสามารถติดต่อได้กับ

ผู้ประสานโครงการ.....
ที่อยู่ โรงพยาบาล.....
หมายเลขโทรศัพท์.....

ข้าพเจ้าได้อ่านข้อความเบื้องต้นและได้รับคำอธิบายจนมีความเข้าใจวัตถุประสงค์ กระบวนการ สิทธิหน้าที่ ตลอดจนผลดีและผลเสียที่อาจเกิดขึ้นจากการร่วมโครงการนี้แล้ว ข้าพเจ้าตัดสินใจโดยอิสระและพร้อมที่จะเข้าร่วมโครงการนี้ และทราบว่าข้าพเจ้าสามารถถอนตัวจากโครงการเมื่อใดก็ได้ โดยไม่เสียสิทธิในการได้รับการรักษาอื่นเท่าที่เป็นไปได้ทั้งในปัจจุบันและอนาคตจากสถานพยาบาลแห่งนี้

.....
ชื่อผู้สมัครเข้าร่วมโครงการ	ลายเซ็น/ลายมือ	วัน/เดือน/ปี
.....
พยาน	ลายเซ็น/ลายมือ	วัน/เดือน/ปี
.....
พยาน	ลายเซ็น/ลายมือ	วัน/เดือน/ปี

ข้าพเจ้าในฐานะผู้ประสานโครงการ/ผู้ดำเนินโครงการได้อธิบายวัตถุประสงค์ของโครงการกระบวนการฯ ต่อผู้สมัครเข้าร่วมโครงการแล้วอย่างดีที่สุดและเห็นว่า ผู้สมัครเข้าร่วมโครงการดังกล่าวมีความเข้าใจและพร้อมจะร่วมมืออย่างเต็มที่

.....
ชื่อผู้ประสานโครงการ	ลายเซ็น/ลายมือ	วัน/เดือน/ปี
/ผู้ดำเนินโครงการ		

หมายเหตุ เมื่อผู้ป่วยเซ็นชื่อในใบสมัครเข้าร่วมโครงการแล้ว ให้ผู้ป่วยเก็บใบสมัครไว้ 1 ชุด
สถานพยาบาลเก็บไว้ 1 ชุด

ส่วนนี้สำหรับผู้ป่วย

Application form for joining the ARV Programme (extended opportunity)
(For use by committees who select patients for the programme)

Background

Name:.....Surname:.....Age:.....
Home address:.....
.....
.....
Telephone:.....
Profession:.....Education.....Economic status.....
Family status.....Number of children:.....
Name of person as a carer:.....
Having been diagnosed as HIV positive in (year).....

Risk factor (infected by)

☐ sexual intercourse ☐ injecting drug user ☐ blood transfusion
☐ no information ☐ others risk factors (please specify).....
Have you ever taken antiretroviral drugs before?
☐ no ☐ yes (please specify a name).....
Are you currently taking antiretroviral drugs?
☐ no ☐ yes

Weight.....kilogrammes High blood pressure.....mm
Lab cbc, wbc.....Hct.....CD4.....Blood group.....

Have you ever had an opportunistic infection or any symptoms?

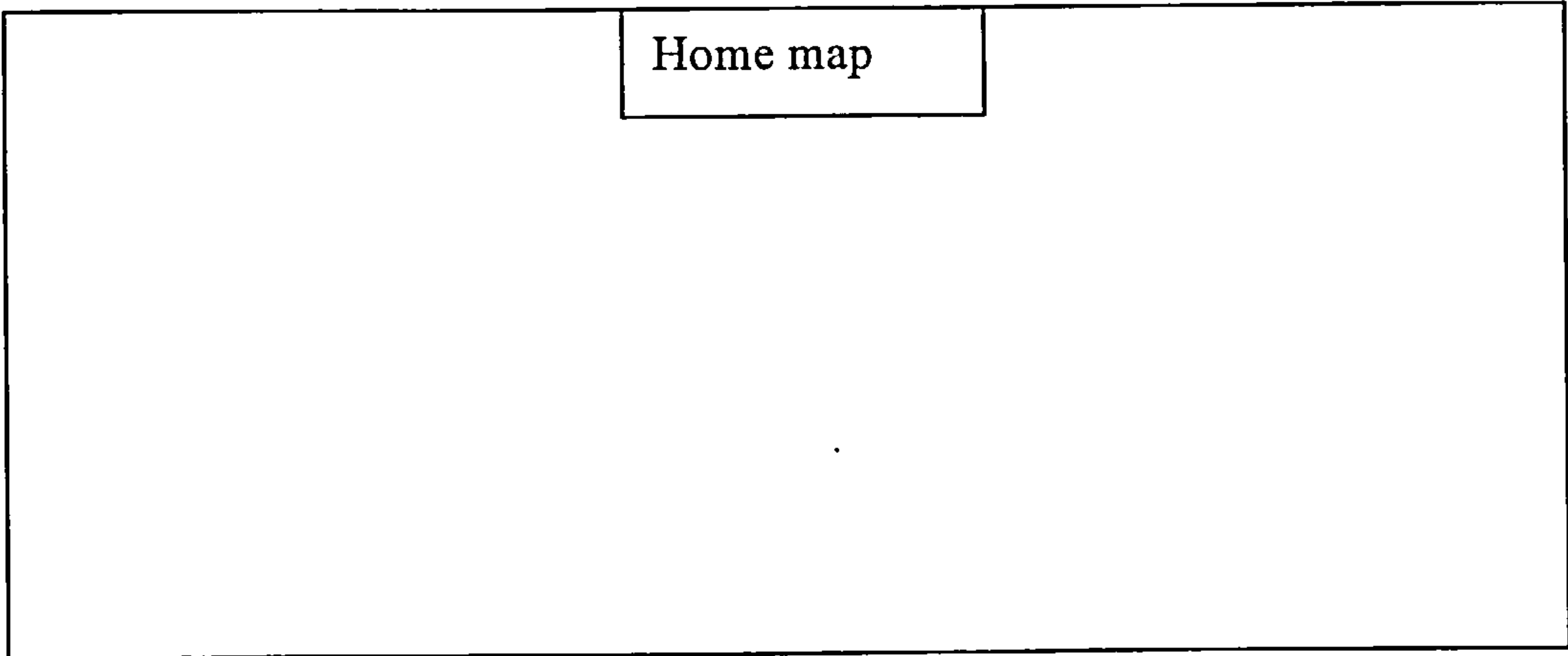
1. Oral candidiasis/OC	<input type="checkbox"/> yes	<input type="checkbox"/> no
2. Herpes Zoster	<input type="checkbox"/> yes	<input type="checkbox"/> no
3. Herpes simplex (longer than a month)	<input type="checkbox"/> yes	<input type="checkbox"/> no
4. Chronic/infected diarrhea	<input type="checkbox"/> yes	<input type="checkbox"/> no
5. Chronic fever	<input type="checkbox"/> yes	<input type="checkbox"/> no
6. Skin diseases such as fungal dermatitis, pruritic popular eruption orscabies	<input type="checkbox"/> yes	<input type="checkbox"/> no
7. Tuberculosis	<input type="checkbox"/> yes	<input type="checkbox"/> no
8. Pneumocystis carinii pneumonia (PCP)	<input type="checkbox"/> yes	<input type="checkbox"/> no
9. Pneumonia bacterial (temporarily)	<input type="checkbox"/> yes	<input type="checkbox"/> no

10. Cryptococcal meningitis [] yes [] no

Other information

- 1. Head of family or others (such as carer for children/old parents).....
- 2. Any difficulties on distance/areas/convenience for communicating/ attending appointments?.....
- 3. Are family and relatives ready to look after you if necessary?.....
- 4. Member of.....(a name of group)? what do you sacrifice/devote or contribute to the community? (role and position in community).....
- 5. Others.....

Signature.....Interviewer
Signature.....Applicant
Signature.....Witness



แบบบันทึกผู้สมัครเข้าโครงการกินยาต้านไวรัสเอดส์ (ขยายโอกาส)
(ใช้ประกอบการให้ข้อมูลแก่คณะกรรมการฯ พิจารณาคัดเลือกผู้ติดเชื้อเข้าโครงการ)

ข้อมูลเบื้องต้น

ชื่อนามสกุล.....อายุ.....ปี
ที่อยู่ บ้านเลขที่..... หมู่.....ชื่อหมู่บ้าน.....ตำบล.....
อำเภอ.....จังหวัด.....โทรศัพท์.....
อาชีพ.....การศึกษา.....ฐานะทางเศรษฐกิจ.....
สถานะ.....จำนวนบุตร.....คน ผู้ดูแลยามเจ็บป่วยคือ.....
ตรวจพบว่าติดเชื้อ HIV เมื่อ ปี พศ.....
ปัจจัยเสี่ยง
☐ เพศสัมพันธ์ ☐ ดินยาเสพติดชนิดฉีดเข้าเส้น ☐ รับเลือดที่มีเชื้อเอดส์
☐ ไม่ทราบ ☐ อื่นๆที่สงสัยอาจเป็นปัจจัยเสี่ยงระบุ.....
เคยกินยาต้านไวรัสมาก่อนหรือไม่ () ไม่เคย () เคย ระบุชื่อ.....
ขณะนี้ยังคงกินยาหรือไม่ () ไม่กิน () กิน
น้ำหนักตัว.....กิโลกรัม ความดันโลหิต.....มม.ปรอท
Lab cbc, wbc.....Hct.....CD4.....Blood gr.....

เคยเป็นโรคติดเชื้อฉวยโอกาสหรือมีอาการดังต่อไปนี้หรือไม่

- | | | |
|-----------------------------------|------------|---------------|
| 1. เชื้อราในปาก | () เคย | () ไม่เคย |
| 2. งูสวัด | () เคย | () ไม่เคย |
| 3. เริ่มนานเกินหนึ่งเดือน | () เคย | () ไม่เคย |
| 4. อูจจาระร่วงเรื้อรัง | () เคย | () ไม่เคย |
| 5. ไข้เรื้อรัง | () เคย | () ไม่เคย |
| 6. ฟันผิวหนักอักเสบ | () เคย | () ไม่เคย |
| 7. วัณโรค | () เคย | () ไม่เคย |
| 8. ปอดอักเสบจาก PCP | () เคย | () ไม่เคย |
| 9. ปอดอักเสบเป็นๆหายๆ | () เคย | () ไม่เคย |
| 10. เยื่อหุ้มสมองอักเสบจากเชื้อรา | () เคย | () ไม่เคย |

ข้อมูลอื่น

- 1. เป็นหัวหน้าครอบครัว / หรือมีความสำคัญอื่นๆ (มีบุตรต้องดูแล / พ่อแม่ชราภาพมากแล้ว.....
- 2. ระยะทาง/ พื้นที่ / ความสะดวกในการติดต่อ / การมาตามนัด (เป็นอุปสรรคอย่างไร)
.....
.....
.....
- 3. ความพร้อมของครอบครัวและญาติ ในการดูแล
.....
.....
.....
- 4. เป็นสมาชิกกลุ่ม ? มีความเสี่ยงหรือทำตนให้เป็นประโยชน์ต่อส่วนรวมชุมชนอะไรบ้าง (บทบาท ตำแหน่ง ในชุมชน)
.....
.....
.....
- 5.อื่นๆ.....
.....

ลงชื่อ.....ผู้สัมภาษณ์
ลงชื่อ.....ผู้สมัคร
ลงชื่อ.....พยาน

แผนที่บ้าน

Consent Form for Revealing of Blood Test Result

At.....

Date.....

I (Mr/Mrs/Miss).....age.....years
give consent for blood test result and treatment history of (Mr/Mrs/Miss.....)
who has been treated and had blood test for being diagnosed as HIV patient or
AIDS patient, to be revealed for the purpose of

- [] support from other organisations
- [] scholarships of children
- [] treatment in other hospitals
- [] others (please specify).....

In doing this, I acknowledge that staff have not breached confidentiality to others
and I cannot take issue with others’ knowledge of blood test results. I have signed
my name as evidence of my consent for blood test results to be revealed.

Signature.....consent giver
(.....)

Signature.....witness
(.....)

Signature.....witness
(.....)

หนังสือยินยอมให้เปิดเผยผลเลือด

เขียนที่.....

วันที่.....เดือน.....พ.ศ.....

ข้าพเจ้า(นาย,นาง,นางสาว).....อายุ.....ปี

ยินยอมให้เปิดเผยผลเลือดและประวัติการรักษาพยาบาลของ (นาย,นาง,นางสาว,เด็กชาย,เด็กหญิง)
.....ซึ่งเป็นผู้ได้รับการตรวจรักษาและรับการเจาะเลือดเพื่อวินิจฉัยว่า
เป็นผู้ติดเชื้อเอชไอวี,เป็นผู้ติดเชื้อมีอาการหรือเป็นผู้ป่วยเอดส์เพื่อ

☐ การขอรับการช่วยเหลือจากหน่วยงานองค์กรต่างๆ

☐ ประกอบการขอรับทุนการศึกษาของบุตร

☐ ประกอบการรักษาพยาบาลยังสถานพยาบาลอื่น

☐ อื่นๆระบุ.....

โดยไม่ถือว่าผู้ปฏิบัติงานได้ละเมิดนำความลับดังกล่าวไปเปิดเผยต่อผู้อื่นและข้าพเจ้าไม่ขอ
กล่าวโทษเอาผิดแก่ผู้ปฏิบัติงาน ข้าพเจ้าจึงลงลายมือชื่อไว้เป็นหลักฐานเพื่อยืนยันในความยินยอมใน
ใบยินยอมให้เปิดเผยผลเลือด

ลงชื่อ.....ผู้ให้ความยินยอม

(.....)

ลงชื่อ.....พยาน

(.....)

ลงชื่อ.....พยาน

(.....)

Glossary

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
AZT	The brand name for zidovudine (ZDV)
CA	Conversation Analysis
CD4 Cell	CD4 lymphocyte, an infection-fighting white blood cell
DA	Discourse Analysis
GPA	The Global Program on AIDS
GPO-Vir	Antiretroviral drugs produced by Thai Pharmaceutical Organization of Thailand
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
Q&A	Question and Answer
NESDB	National Economic and Social Development Board
VCT	Voluntary Counselling and Testing
WHO	The World Health Organization

References

- Akeroyd, A. V. (1984) Ethics in Relation to Informants, the Profession and Governments. In Ellen, R. F. (ed.) *Ethnographic Research: a Guide to General Conduct*. London: Academic Press, pp. 133-154.
- Akeroyd, A. V. (2004) Coercion, Constraints, and "Cultural Entrapments": A Future Look at Gendered and Occupational Factors Pertinent to the Transmission of HIV in Africa. In: Kalipeni, E., et al., (eds) *HIV and AIDS in Africa*. Malden MA: Blackwell Publishing, pp. 89-103.
- Amico, K.R., Toro-Alfonso, J. and Fisher, J.D. (2005) An Empirical Test of the Information, Motivation and Behavioral Skills Model of Antiretroviral Therapy Adherence. *AIDS Care*, 17(6): 661-673.
- Anon. (no date) คนไข้ตายในรพฯไม่ได้นะ เดี่ยวมีเรื่อง. *A Patient Cannot Die in a Community Hospital, That Will Make Trouble* [online]. Available at: <URL:http://www.geocities.com/rural_doctor/Chapter/c_death.html> [Accessed 30 June 2006].
- Ariès, P. T. (1976) *Western Attitudes Towards Death*. London: Marion Boyars Publishers.
- Asia Pacific Network of People Living with HIV/AIDS. (2004) *AIDS Discrimination in Asia* [online]. Available at: <URL:<http://www.gnpplus.net/regions/asiapac.html>> [Accessed 4 October 2005].
- Atkinson, J. M. (1982) Understanding Formality: Notes on the Categorisation and Production of "Formal" Interaction. *British Journal of Sociology*, 33: 86-117.
- Atkinson, J. M. (1984) *Our Masters' Voices: the Language and Body Language of Politics*. New York: Routledge.
- Atkinson, J. M. and Heritage, J. (1984) *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press.
- Atkinson, P., et al., (eds) (2001) *Handbook of Ethnography*. London: Sage.
- Austin, J. L. (1962) *How to Do Things with Words*. Oxford: Oxford University Press.
- Ayto, J. (2003) *The Oxford Dictionary of Slang*. Oxford: Oxford University Press.
- Barnett, T. and Whiteside, A. (2002) *AIDS in the Twenty-First Century: Disease and Globalization*. New York: Palgrave-Macmillan.
- Barry, J. (1994) *Training Handbook for Counseling Skills*. Bangkok: Chulalongkorn

University Press.

- Bhatiasevi, A. (2002) Ministry Begins Testing GPO-Vir:Anti-retroviral to Be Used at 400 Hospitals. *Bangkok Post* Friday 20 December 2002 [online]. Available at:<URL:<http://www.aegis.com/news/bp/2002/BP021206.html>> [Accessed 8 November 2005].
- Boden, D. and Zimmerman, D. H. (1991) *Talk and Social Structures: Studies in Ethnomethodology and Conversation Analysis*. Cambridge: Polity Press.
- Bor, R. and Miller, R. (1988) Counselling in Action Addressing 'Dread Issues': A Description of a Unique Counselling Intervention with Patients with AIDS/HIV. *Counselling Psychology Quarterly*, 1(4): 397-406.
- Bor, R., Miller, R. and Goldman, E. (1992) *Theory and Practice of HIV Counselling: a Systematic Approach*. London: Cassell.
- Bourgois, P. I. (1996) *In Search of Respect: Selling Crack in El Barrio*. 2nd edn. Cambridge: Cambridge University Press.
- British Sociological Association (2002). *Statement of Ethical Practice for the British Sociological Association*. [online]. Available at: <URL: <http://www.sociology.org.uk/as4bsoce.pdf>> [Accessed 15 February 2006].
- Brown, G. and Yule, G. (1983) *Discourse Analysis*. Cambridge: Cambridge University Press.
- Bryman, A. (ed.) (2001) *Ethnography*. (volume 1-4) London: Sage.
- Bull, P. (1983) *Body Movement and Interpersonal Communication*. Chichester: John Wiley & Sons.
- Burnard, P. (1990) *Learning Human Skills*. 2nd edn. Oxford: Butterworth-Heinemann.
- Burnard, P. (1991) *Coping with Stress in Health Professions*. London: Chapman & Hall.
- Burnard, P. (1992) *Counselling: a Guide to Practice in Nursing*. Oxford: Butterworth-Heinemann Ltd.
- Burnard, P. (1997) *Effective Communication Skills for Health Professionals*. 2nd edn. London: Stanley Thornes (Publishers) Ltd.
- Burnard, P. (2005) *Counselling Skills for Health Professionals*. 4th edn. Cheltenham: Nelson Thornes Ltd.
- Burnard, P. and Kendrick, K. (1998) *Ethical Counselling: A Workbook for Nurses*. London: Arnold.

- Burnard, P. and Naiyapatana, W. (2004) *Culture and Communication in Thai Nursing*. Cardiff: The University of Wales College of Medicine.
- Buttny, R. (1993) *Social Accountability in Communication*. London: Sage.
- Button, G. and Casey, N. (1984) Generating Topic: the Use of Topic Initial Elicitors. In: Atkinson, J.M. and Heritage, J. *Structures of Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press, pp. 167-190.
- Byrne, P. S. and Long, B. E. L. (1976) *Doctors Talking to Patients: a Study of the Verbal Behaviour of General Practitioners Consulting in Their Surgeries*. London: Her Majesty's Stationery Office
- Carey, T. C., Carey, M. P. and Kelley, M. L. (1997) Differential Emotions Theory: Relative Contribution of Emotion, Cognition and Behaviour to the Prediction of Depressive Symptomatology in Non-Referred Adolescents. *Journal of Clinical Psychology*, 53(1): 25-34.
- Chatwin, J. (2003) *Communication in Homoeopathic Therapeutic Encounters*. Unpublished Ph.D. thesis, Department of Sociology, University of York, England.
- Cherry, K. and Smith, D. (1993) Sometimes I cry: The Experience of Loneliness for Men with AIDS. *Health Communication*, 5(3): 181-208.
- Cicirelli, V. G. (2001) Personal Meanings of Death in Older Adults and Young Adults in Relation to Their Fears of Death. *Death Studies*, 25(8): 663-683.
- Clayman, S.E. and Maynard, D.W. (1995) Ethnomethodology and Conversation Analysis. In: ten Have, P. and Psathas, G. (eds) *Situated Order*. London: University Press of America, Inc., pp. 1-30.
- Collins, S. (forthcoming) Communicating for a Clinic Purpose: Strategy in Interaction in Health Care Consultation. *Communication Medicine* [Special Issue, 'Professional Theories and Institutional Interaction' (ed.) A. Peräkylä].
- Corbetta, P. (2003) *Social Research: Theory, Methods and Techniques*. London: Sage.
- Cote, T.R., Biggar, R.J. and Dannenberg, A.L. (1992) Risk of Suicide amongst Person with AIDS: a National Assessment. *Journal of American Medicine Association*. 268(15): 2066-2068.
- Coulon, A. (1995) *Ethnomethodology*. Thousand Oaks: Sage.
- Dane, B. (2002) Disclosure: the Voices of Thai Women Living with HIV/AIDS. *International Social Work*, 45(2): 185-204.
- Denzin, N.K. and Lincoln, Y.S. (2005) *The Sage Handbook of Qualitative Research*. 3rd edn. London: Sage.

- Department of Communicable Disease Control (2001) *Projections for HIV/AIDS in Thailand: 2000-2020: the Thai Working Group on HIV/AIDS Projection*. Bangkok: Karnsana Printing Press.
- Department of Mental Health (1996) *Handbook for AIDS Counselling*. Bangkok: Ministry of Public Health.
- Drew, P. (1994) Conversation Analysis. In: R.E. Asher and J.M.Y. Simpson (eds) *The Encyclopedia of Language and Linguistics*, Vol. 2. Oxford: Pergamon Press, pp. 749-754.
- Drew, P. (2003) Conversation Analysis. In: Smith, J. A. (ed.) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage, pp. 132-158.
- Drew, P. (2005) Conversation Analysis. In: Fitch, K.L. and Sanders, R.E. (eds) *Handbook of Language and Social Interaction*. London: Lawrence Erlbaum Associates, pp.149-171.
- Drew, P. and Heritage, J. (eds) (1992) *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press.
- Drew, P. and Heritage, J. (eds) (2006) *Conversation Analysis: Sage Benchmark in Social Research Methods* (vol. 1-4). London: Sage
- Drew, P. and Holt , E. (1998) Figures of Speech: Figurative Expressions and the Management of Topic Transition in Conversation. *Language in Society*, 27: 495-522.
- Drew, P. and Sorjonen, M.-L. (1997) Institutional Dialogue. In: van Dijk, T. A. (ed.) *Discourse as Social Interaction*. London: Sage, pp. 92-118.
- Durkheim, E. (1952) *Suicide: a Study of Sociology*. London: Routledge.
- Edwards, D. (2000) Extreme Case Formulations: Softeners, Investment, and Doing Nonliteral. *Research on Language and Social Interaction*, 33(4): 347-373.
- Emerson, R. M., Fretz, R. I. and Shaw, L. L. (1995) *Writing Ethnographic Fieldnotes*. Chicago: Chicago Press.
- Garfinkel, H. (1967) *Studies in Ethnomethodology*. New Jersey: Prentice-Hall.
- Glaser, B. G. and Strauss, A. L. (1965) *Awareness of Dying*. Chicago: Aldine.
- Glaser, B. G. and Strauss, A. L. (1968) *Time for Dying*. Chicago: Aldine.
- Global Health Reporting.Org (2006) *HIV/AIDS in Thailand*. [online]. Available at:<URL:<http://www.globalhealthreporting.org/countries/thailand.asp?collID=13&id=36&malID=152&tbID=151&hivIC=153&malIC=155&tbIC=154&map=156&con=Thailand&p=1>> [Accessed 30 June 2006].

- Goffman, E. (1983) The Interaction Order: American Sociological Association, 1982 Presidential Address. *American Sociological Review*, 48(February): 1-17.
- Goward, N. (1984) Personal Interaction and Adjustment. In: Ellen, R. F. (ed.) *Ethnographic Research: a Guide to General Conduct*. London: Academic Press, pp. 100-108.
- Green, J. and Green, M. (1992) *Dealing with Death: Practices and Procedures*. London: Chapman & Hall.
- Haakana, M. (2001) Laughter as a Patient's Resource: Dealing with Delicate Aspects of Medical Interaction. *Text*, 21(1/2): 187-219.
- Halldorsdottir, I. (2006) *The Client's Instructions: Lawyer-Client Interaction and Criminal Defence Case Preparation*. Unpublished Ph.D. thesis, Department of Sociology, University of York, England.
- Heath, C. (1986) *Body Movement and Speech in Medical Interaction*. Cambridge: Cambridge University Press.
- Heinemann, T. (2003) *Negation in Conversation, In Danish*. Unpublished Ph.D. thesis, Department of Sociology, University of York, England.
- Henley, S. (1983) Bereavement by Suicide: the Effect of a Suicidal Death upon Surviving Relatives. *Bereavement Care*, 2: 6-7.
- Hepburn, A. (2004) Crying: Notes on Description, Transcription, and Interaction. *Research on Language and Social Interaction*, 37 (3): 251-290.
- Heritage, J. (1984) *Garfinkel and Ethnomethodology*. Cambridge: Polity Press.
- Heritage, J. (1995) Conversation Analysis: Methodological Aspects. In: Quasthoff, U.M. (ed.) *Aspects of Oral Communication*. New York: Walter de Gruyter, pp. 391-418.
- Heritage, J. (1997) Conversation Analysis and Institutional Talk: Analysing Data. In: Silverman, D.(ed.) *Qualitative Research: Theory, Method and Practice*. London: Sage, pp. 161-182.
- Heritage, J. and Atkinson, J.M. (1984) Introduction. In: Atkinson, J.M. and Heritage, J. (eds) *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press, pp. 1-15.
- Heritage, J. and Sefi, S. (1992) Dilemmas of Advice: Aspects of the Delivery and Reception of Advice in Interactions between Health Visitors and First-Time Mothers. In: Drew, P. and Heritage, J. (eds) *Talk at Work: Interaction in Institutional Settings*. Cambridge: Cambridge University Press, pp. 359 - 417.
- Howarth, G. and Leaman, O. (eds) (2001) *Encyclopedia of Death and Dying*. London: Routledge.

- Hunter, S. (2005) *AIDS in Asia: a Continent in Peril*. New York: Palgrave Macmillan.
- Hutchby, I. (2006) *Media Talk: Conversation Analysis and the Study of Broadcasting*. Glasgow: Open University Press.
- Hutchby, I. and Wooffitt, R. (1998) *Conversation Analysis: Principles, Practices and Applications*. Cambridge: Polity Press.
- Iwasaki, S. and Ingkaphirom Horie, P. (2000) Creating Speech Register in Thai Conversation. *Language in Society*, 29: 519-554.
- Jaworski, A. and Coupland, N. (1999) (eds) Introduction: Perspectives on Discourse Analysis. In: Jaworski, A. and Coupland, N. (eds) *The Discourse Reader*. London: Routledge, pp. 1-44.
- Jefferson, G. (1984a) Transcript Notation. In: Atkinson, J.M. and Heritage, J. (eds), *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press, pp. ix-xvi.
- Jefferson, G. (1984b) On the Organization of Laughter in Talk About Troubles. In: Atkinson, J. M. and Heritage, J. (eds) *Structures of Social Action: Studies in Conversation Analysis*. Cambridge: Cambridge University Press, pp. 346-369.
- Jefferson, G. (1990) List-Construction as a Task and Resource. In: Psathas, G. (ed.) *Interaction Competence*. Lanham Maryland: University Press of America, pp. 63-92.
- Karnpisit, T. (2000) *Integration of AIDS into National Development Planning: the Case of Thailand*. Nonthaburi: Petchrung Press.
- Kawichai, C., et al., (2004) HIV Incidence and Risk Behaviours after Voluntary HIV Counselling and Testing (VCT) among Adults Aged 19-35 Years Living in Peri-Urban Communities around Chiang Mai City in Northern Thailand, 1999. *AIDS Care*, 16(1): 21-35.
- Kitajima, T., et al., (2005) Access to Antiretroviral Therapy Among HIV/AIDS Patients in Khon Kaen Province, Thailand. *AIDS Care*, 17(3): 359-366.
- Kittikanya, C. (2004) Budget Allocation Woes. *Bangkok Post Economic Review Year-End 2004* [online]. Available at: <URL:<http://www.bangkokpost.net/ecoreviewye2004/health.html>> [Accessed 8 November 2005].
- Kitzinger, C. (2006) Talking Sex and Gender. In: Drew, P., Raymond, G., and Weinberg, D. (eds) *Talk and Interaction in Social Research Methods*. London: Sage, pp. 155-170.
- Knodel, J. and Saengtienchai, C. (2002) *AIDS and Older Persons: the View from Thailand*. Michigan: Population Studies Center.

- Koetsawang, S. (1999) *การให้คำปรึกษา [Counselling]*. Bangkok: Sam Charoen Panitch.
- Kübler -Ross, E. (1969) *On Death and Dying*. London: Routledge.
- Kübler-Ross, E. (1987) *AIDS: the Ultimate Challenge*. New York: Macmillan Publishing.
- Lee, R. M. (1993) *Doing Research on Sensitive Topics*. London: Sage.
- Lee, R. M. (2000) *Unobtrusive Methods in Social Research*. Buckingham: Open University Press.
- Levinson, S. C. (1983) *Pragmatics*. Cambridge: Cambridge University Press.
- Lindlof, T. R. and Taylor, B.C. (2002) *Qualitative Communication Research Methods*. Thousand Oaks: Sage.
- Longhofer, J. (1980) Dying or Living?: the Double Bind. *Culture, Medicine and Psychiatry*, 4(2): 119-136.
- Lutfey, K. and Maynard, D. W. (1998) Bad News in Oncology: How Physician and Patient Talk About Death and Dying without Using Those Words. *Social Psychology Quarterly*, 61(4): 321-341.
- Lyttleton, C. (2000) *Endangered Relations: Negotiating Sex and AIDS in Thailand*. Amsterdam: Harwood Academic Publishers.
- Mason, J. (2002) *Qualitative Researching*. 2nd edn. London: Sage.
- Maynard, D.W. (2003) *Bad News, Good News: Conversational Order in Everyday Talk and Clinical Settings*. London: University of Chicago Press.
- McLeod, J. (2001) *Qualitative Research in Counselling and Psychotherapy*. London: Sage.
- McManus, T. (1989) Male Homosexual Sexual Behaviour. In: Green, J. and McCreaner, A. *Counselling in HIV Infection and AIDS*. Oxford: Blackwell Scientific Publications, pp. 224-232.
- Miller, R. and Bor, R. (1991) *AIDS: a Guide to Clinical Counseling*. Philadelphia: Science Press.
- Moatti, J-P. and Spire, B. (2000) Living with HIV/AIDS and Adherence to Antiretroviral Treatments. In: Moatti, J-P. et al., *AIDS in Europe: New Challenges for the Social Sciences*. London: Routledge, pp. 57-73.
- Moerman, M. (1988) *Talking Culture: Ethnographic and Conversation Analysis*. Philadelphia: University of Pennsylvania Press.
- Müller, O., et al., (1995) Sexual Risk Behaviour Reduction Associated with

- Voluntary HIV Counselling and Testing in HIV Infected Patients in Thailand. *AIDS Care*, 7(5): 567-572.
- Myers, G. (1998) Displaying Opinions: Topics and Disagreement in Focus Groups. *Language in Society*, 27: 85-111.
- Naksakul, K. (1998) ระบบเสียงภาษาไทย [*Thai Sound System*]. Faculty of Arts Publications Project. Bangkok: Chulalongkorn University Press.
- Nilchaikovit, T. (1993a) เทคนิคการให้บริการปรึกษาแนะนำเกี่ยวกับการติดเชื้อ HIV (ตอนที่ ๑). [Techniques for HIV Counselling 1] *คลินิกเวชปฏิบัติปริทัศน์ [Clinic]*, 9(4): 216-225.
- Nilchaikovit, T. (1993b) เทคนิคการให้บริการปรึกษาแนะนำเกี่ยวกับการติดเชื้อ HIV (ตอนที่ ๒). [Techniques of HIV Counselling 2] *คลินิกเวชปฏิบัติปริทัศน์ [Clinic]*, 9(6): 385-394.
- Nilchaikovit, T. (1994) เทคนิคการให้การปรึกษาผู้ป่วย HIV [*Counselling Techniques for HIV Patients*]. Bangkok: Moh-Chao-Ban Publishing.
- Nilchaikovit, T. (2003) Discussion with Pairote Wilainuch, 25 April.
- Nilchaikovit, T., Hill, J. M. and Holland, J. C. (1993) The Effects of Culture on Illness Behavior and Medical Care. *General Hospital Psychiatry*, 15: 41-50.
- Nord, D. (1996) Issues and Implications in the Counselling of Survivors of Multiple AIDS-Related Loss. *Death Studies*, 20(4): 389-413.
- O'Dowd, M.A. and Zofnass, J.S. (1991) Neuropsychiatric and Psychosocial Factors in the Rehabilitation of Patients with AIDS. In: Mukand, J. (ed.) *Rehabilitation for Patients with HIV Disease*. New York: McGraw-Hill.
- Office of Public Affairs (2003) *Thailand's Program to Prevent Mother-to-Child HIV Transmission*. Bangkok: U.S. Embassy in Thailand [online]. Available at: <URL:<http://bangkok.usembassy.gov/apec2003/pressbackgroundflotus.htm>> [Accessed 23 June 2006].
- Oxfam International (2004) *Free Trade Agreement Between the USA and Thailand Threatens Access to HIV/AIDS Treatment (Oxfam Briefing Note)*. [Online]. Available at: <URL:http://www.oxfam.org.uk/what_we_do/issues/health/bn_fta_hivaids.htm>
- Parry, M. (2001) AIDS in Asia is Spreading at Devastating Rate. *Bangkok Post* 4 June 2001:10.
- Pattaravanich, U. (1998) *Using Media for Modification of Sexual Opinions and Behaviour among Adolescents: Case Study in a Commercial College in Bangkok*. Nakhorn Pathom: Institute of Population and Social Research, Mahidol University.
- Peräkylä, A. (1993) Invoking a Hostile World: Discussing the Patient's Future in

- AIDS Counselling. *Text*, 13(2): 291-316.
- Peräkylä, A. (1995) *AIDS Counselling: Institutional Interaction and Clinical Practice*. Cambridge: Cambridge University Press.
- Peräkylä, A. (1997) Reliability and Validity in Research Based on Tapes and Transcripts. In Silverman, D. (ed.) *Qualitative Research: Theory, Methods and Practice*. London: Sage.
- Peräkylä, A. (2005) Analyzing Talk and Text. In: Denzin, N.K. and Lincoln, Y.S. (eds) *The Sage Handbook of Qualitative Research*. 3rd edn. London: Sage Publications, pp. 869-886.
- Peräkylä, A. and Bor, R. (1990) Interactional Problems of Addressing 'Dreaded Issues' in HIV-Counselling. *AIDS Care*, 2(4): 325-338.
- Phra Dhammapidok (Prayut Prayutto) (2000). *Dictionary of Buddhism*. Bangkok: Mahachulalongkornrajavidyalalai.
- Podhisita, C. (2004) ศาสตร์และศิลป์แห่งการวิจัยเชิงคุณภาพ [*Qualitative Research*]. Bangkok: Amarin Printing and Publishing.
- Pomerantz, A. (1986) Extreme Case Formulations: a Way of Legitimizing Claims. *Human Studies*, 9: 219-229.
- Pomerantz, A. and Fehr, B.J. (1997) Conversation Analysis: An Approach to The Study of Social Action as Sense Making Practices. In: van Dijk, T. A. van (ed.) *Discourse as Social Interaction*. London: Sage, pp. 64-91.
- Pomerantz, A. and Mandelbaum, J. (2005) Conversation Analytic Approaches to The Relevance and Uses of Relationship Categories in Interaction. In: Fitch, K.L. and Sanders, R.E. (eds) *Handbook of Language and Social Interaction*. London: Lawrence Erlbaum Associates, pp. 149-171.
- Pongpaiboj, N. (2006) Discussion with Pairote Wilainuch, June.
- Psathas, G. (1990) Introduction: Methodological Issues and Recent Developments in the Study of Naturally Occurring Interaction. In: Psathas, G. (ed) *Interaction Competence*. Lanham Maryland: University Press of America, pp. 1-29.
- Psathas, G. (1995) *Conversation Analysis: the Study of Talk-in-Interaction*. London: Sage.
- Robinson, J. D. (2003) An Interactional Structure of Medical Activities During Acute Visits and Its Implications for Patients' Participation. *Health Communication*, 15(1): 27-59.
- Rohleder, P. and Swartz, L. (2005) "What I've noticed what they need is the stats": Lay HIV Counsellors' Reports of Working in a Task-Orientated Health Care System. *AIDS Care*, 17(3): 397-406.

- Rossman, G. B. and Rallis, S. F. (2003) *Learning in the Field: An Introduction to Qualitative Research*. 2nd edn. London: Sage.
- Roth, N. L. and Nelson, M. S. (1997) HIV Diagnosis Rituals and Identity Narratives. *AIDS Care*, 9(2): 161-179.
- Sacks, H., Schegloff, E. A. and Jefferson, G. (1978) A Simplest Systematics for the Organization of Turn Taking for Conversation. In: Schenkein, J. (ed.) *Studies in the Organization of Conversational Interaction*. New York: Academic Press, pp. 7-55.
- Schegloff, E. A. (1987) Between Macro and Micro: Contexts and Other Connections. In: Alexander, J. C., et al., (eds) *The Micro-Macro Link*. Berkeley and Los Angeles: University of California Press, pp. 207-234.
- Schegloff, E. A. (1991) Reflections on Talk and Social Structure. In: Boden, D. and Zimmerman, D. H. (eds) *Talk & Social Structure: Studies in Ethnomethodology and Conversation Analysis*. Cambridge: Polity Press, pp. 44-70.
- Schegloff, E.A., Jefferson, G. and Sacks, H. (1977) The Preference for Self-Correction in the Organization of Repair in Conversation. *Language*. 53(2): 361-382.
- Schenkein, J. (ed.) (1978) *Studies in the Organization of Conversational Interaction*. New York: Academic Press.
- Schwandt, T. A. (2001) *Dictionary of Qualitative Inquiry*. 2nd edn. California: Sage.
- Seale, C. (1998) *Constructing Death*. Cambridge: Cambridge University Press.
- Shovein, J. (2003) *The Role of Public Health Nurses*. The American Public Health Association [online]. Available at: <URL:<http://www.csuchico.edu/~horst/about/roles.html>> [Accessed 30 June 2006].
- Silverman, D. (1997) *Discourse of Counselling: HIV Counselling as Social Interaction*. London: Sage.
- Silverman, D. (1998) *Harvey Sacks: Social Science & Conversation Analysis*. Cambridge: Cambridge University Press.
- Silverman, D. (2000) *Doing Qualitative Research: A Practical Handbook*. London: Sage.
- Silverman, D. (2001) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. 2nd edn. London: Sage.
- Silverman, D. and Peräkylä, A. (1990) AIDS Counselling: the Interactional Organisation of Talk About 'Delicate' Issues. *Sociology of Health & Illness*, 12(3): 293 - 318.

- Singhanetra-Renard, A., Chongsatitmun, C. and Aggleton, P. (2001) Care and Support for People Living with HIV/AIDS in Northern Thailand: Findings from an In-Depth Qualitative Study. *Culture, Health & Sexuality*, 3(1): 167-182.
- Sittitrai, W., Brown, T. and Sakondhavat, C. (1993) Levels of HIV Risk Behaviour and AIDS Knowledge in Thai Men Having Sex with Men. *AIDS Care*, 5(3): 261-271.
- Small, N. (1993) *AIDS: the Challenge: Understanding, Education and Care*. Aldershot: Avebury.
- Smyth, D. (2002) *Thai: an Essential Grammar*. London: Routledge.
- Songwathana, P. and Manderson, L. (1998) Perceptions of HIV/AIDS and Caring for People with Terminal AIDS in Southern Thailand. *AIDS Care*, 10 (Supplement 2): S155-S165.
- Songwathana, P. and Manderson, L. (2001) Stigma and Rejection: Living with AIDS in Villages in Southern Thailand. *Medical Anthropology*, 20: 1-23.
- Southern African AIDS Trust. (2001) *Basic AIDS Counselling Guidelines*. online], Available at:<URL:<http://www.satregional.org/attachments/Publications/Skills%20Training%20E/Basic%20Counselling%20Skills.pdf>> [Accessed 30 June 2006].
- Sudnow, D. (1967) *Passing On: the Social Organization of Dying*. New Jersey: Prentice-Hall.
- Sutton-Spence, R. and Woll, B. (1999) *The Linguistics of British Sign Language: an Introduction*. Cambridge: Cambridge University Press.
- Tambiah, S. J. (1970) *Buddhism and the Spirit Cults in North-East Thailand*. Cambridge: Cambridge University Press.
- Tan, M.L. (2005) *Access to Medicines* [online]. Available at: <URL:http://www.inq7.net/opi/2004/jul/16/opi_mltan-1.htm> [Accessed 12 November 2005].
- ten Have, P. (1999) *Doing Conversation Analysis: A Practical Guide*. London: Sage.
- ten Have, P. (2001) Applied Conversation Analysis. In: McHoul, A. and Rapley, M. (eds) *How to Analyse Talk in Institutional Settings*. London: Continuum, pp. 3-11.
- ten Have, P. (2004) *Understanding Qualitative Research and Ethnomethodology*. London: Sage.
- Thanaprasertgorn, A. and Nilchaikovit, T. (1997a) Thai Patients' Perspectives About Truth Telling. *Journal of the Psychiatric Association of Thailand*, 42(4): 212-219.

- Thanaprasertgorn, A. and Nilchaikovit, T. (1997b) Thai Physicians' Attitudes Towards Truth Telling. *Journal of the Psychiatric Association of Thailand*, 42(4): 220-225.
- The Community Program Rapporteurs Team (2004) *Summaries Community Program*. [online], Available at: <URL:<http://www.aids2004.org/subpage.aspx?pageId=278>> [Accessed 28 November 2005].
- The Ministry of Public Health, World Health Organization and UNAIDS (2000) *Evaluation of Voluntary Counselling and Testing in the National Prevention of Mother to Child Transmission Programme in Thailand*. Geneva.
- The Monitoring the AIDS Pandemic (MAP) (2004) *AIDS in ASIA: Face the Facts*. Bangkok: MAP Network. [Also available at: <URL:http://www.mapnetwork.org/docs/MAP_AIDSinAsia2004.pdf>].
- UNAIDS (1998a) *Partners in Prevention: International Case Studies of Effective Health Promotion Practice in HIV/AIDS*. Geneva: UNAIDS.
- UNAIDS (1998b) *Relationships of HIV and Std Declines in Thailand to Behavioural Change: a Synthesis of Existing Studies*. Geneva: UNAIDS.
- UNAIDS (1999) Sanpatong Home-based Care Project, Thailand. In: *Comfort and Hope: Six Case Studies on Mobilizing Family and Community Care for and by People with HIV/AIDS*, pp. 65-79. Geneva: UNAIDS.
- UNAIDS (2000a) *HIV and Health-Care Reform in Phayao: From Crisis to Opportunity*. Geneva: UNAIDS.
- UNAIDS (2000b) *Protocol for the Identification of Discrimination against People Living with HIV*. Geneva: UNAIDS.
- UNAIDS (2000c) *Tools for Evaluating HIV Voluntary Counselling and Testing*. Geneva: UNAIDS.
- UNAIDS (2000d) *Voluntary Counselling and Testing (VCT)*. Geneva: UNAIDS.
- UNAIDS and the Ministry of Public Health, Thailand (2000) *Evaluation of the 100% Condom Programme in Thailand*. Geneva: UNAIDS.
- UNAIDS (2004a) *2004 Report on the Global AIDS Epidemic*. Geneva: UNAIDS.
- UNAIDS (2004b) *Opening Ceremony* [online] 11 July 2004 UNAIDS: Available at:<URL:http://www.unaids.org/bangkok2004/docs/SP_ThaiPM_15thAIDSConference_11Jul04.pdf> [Accessed 23 August 2005].
- United Nations Development Programme (2001) *Mae Chan Workshop on Integrated Community Mobilization towards Effective Multisectoral HIV/AIDS Prevention and Care*. Bangkok: UNDP South-East Asia HIV and Development Project.

- U.S. Census Bureau (2004) *The AIDS Pandemic in the 21st Century: International Population Reports*. Washington: U.S. Government Printing Office.
- Viddhanaphuti, C. (1999) *A Cultural Approach to HIV/AIDS Prevention and Care, Thailand's Experience Country Report*. UNESCO and UNAIDS.
- Warden, J. (1990) AIDS in Thailand. *British Medical Journal*, 300: 415-416.
- Whyte, W.F. (1943) *Street Corner Society*. 4th edn. London: University of Chicago Press.
- Wilkinson, S. (2003) Focus Groups. In: Smith, J. A. (ed.) *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage, pp. 132-158.
- Wilkinson, S. (2006) Analysing Interaction in Focus Groups. In: Drew, P., Raymond, G. and Weinberg, D. (eds) *Talk and Interaction in Social Research Methods*. London: Sage, pp. 50-62.
- Williams, K. (1992) AIDS Stories Covered Up. *Media Development/Journal of the World Association for Christian Communication*, XXXIX: 9-11.
- Wongrakmit, B. (2003) Discussion with Pairote Wilainuch, 23 May.
- Wooffitt, R. (2005) *Conversation Analysis and Discourse Analysis: a Comparative and Critical Introduction*. London: Sage.
- Wootton, A.J. (1988) Remarks on the Methodology of Conversation Analysis. In: Roger, D. and Bull, P. (eds) *Conversation: An Interdisciplinary Perspective*. Clevedon Philadelphia: Multilingual Matters Ltd, pp. 238-258.
- World Health Organization (1993) *HIV Prevention and Care: Teaching Modules for Nurses and Midwives*. Geneva: WHO.
- World Health Organization (1994a) *An Orientation to HIV/AIDS Counselling: a Guide for Trainers*. New Delhi: WHO.
- World Health Organization (1994b) *Source Book for HIV/AIDS Counselling Training*. Geneva: WHO.
- World Health Organization (1995) *Counselling for HIV/AIDS: A Key to Caring for Policy-Makers, Planners and Implementors of Counselling Activities*. Geneva: WHO.
- World Health Organization (2004) *Country Health Profile – Thailand*. Regional Office for South-East Asia. [online], Available at: <URL:http://w3.whosea.org/EN/Section313/Section1525_6895.htm> [Accessed 15 April 2006].